

SERFF Tracking Number:	HMRK-125683769	State:	Arkansas
Filing Company:	HM Life Insurance Company	State Tracking Number:	39219
Company Tracking Number:	HMP-ACC 308		
TOI:	H02G Group Health - Accident Only	Sub-TOI:	H02G.000 Health - Accident Only
Product Name:	Accident Insurance		
Project Name/Number:	Accident/HMP-ACC 308		

## Filing at a Glance

Company: HM Life Insurance Company

Product Name: Accident Insurance

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only

Filing Type: Form

SERFF Tr Num: HMRK-125683769 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39219

Co Tr Num: HMP-ACC 308

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: Jennifer Bayich

Disposition Date: 06/11/2008

Date Submitted: 06/05/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Accident

Project Number: HMP-ACC 308

Requested Filing Mode:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Exempt from filing in Pennsylvania

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 06/11/2008

State Status Changed: 06/11/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

June 5, 2008

Arkansas Department of Insurance

120 West 3rd Street

Little Rock, AR 72201

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Re: HM Life Insurance Company

NAIC 93440

FEIN 06-1041332

#### Form Filing

Accidental Injury Policy HMP-ACC 308

Accidental Injury Certificate HMC-ACC 308

Dear Sir or Madam:

The above captioned forms are being filed for your review and approval for use in Arkansas. These forms are new do not replace any forms now on file with your department. We are submitting these forms in final print and in compliance with the filing guidelines in your state.

The forms contained in this filing represent HM Life's Accidental Injury product which offers lump sum benefits to covered individuals for accidental injury and health screenings. This plan of insurance will be marketed by HM Life to employer, or similar, groups on a non-contributory, or contributory / voluntary, payroll deduction basis. These forms offer coverage to employees and their dependents. We will not market to any organization for which a filing is required in your state or that is not a group as defined by applicable law. There is no deviation from generally accepted standard insurance practices.

Bracketed items in this filing indicate variable information, and may be removed from some group plans developed. Any or all of the variables could be used in each plan, policy or certificate. Please see the "summary of variables" document.

Also, please note that application form HMWA 308 approved for use by your Department on May 23, 2008 (SERFF Tracking Number HMRK-125652016) will be used with these forms.

These forms have been tested for readability and a readability certification is attached.

If you have any questions, please contact me at the left-side address, or if you prefer at either my direct dial of 412-544-

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<i>Project Name/Number:</i>	<i>Accident/HMP-ACC 308</i>		

0923; or via email at [jennifer.bayich@hminsurancegroup.com](mailto:jennifer.bayich@hminsurancegroup.com).

Thank you in advance for your immediate attention to this filing.

Sincerely,  
Jennifer L. Bayich, Esq  
Compliance Analyst III

Attachments

## Company and Contact

### Filing Contact Information

Jennifer Bayich, Compliance Analyst II  
P.O. Box 535061  
Pittsburgh, PA 15235-5061

[jennifer.bayich@hminsurancegroup.com](mailto:jennifer.bayich@hminsurancegroup.com)  
(412) 544-0923 [Phone]  
(412) 544-1138[FAX]

### Filing Company Information

HM Life Insurance Company  
PO Box 535065  
Suite P6504  
Pittsburgh, PA 15253-5065  
(412) 544-1139 ext. [Phone]

CoCode: 93440  
Group Code: 812  
State of Domicile: Pennsylvania  
Company Type:

Group Name: HM Insurance Group State ID Number:  
FEIN Number: 06-1041332

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	2 forms x \$50 = \$100
Per Company:	No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	\$100.00	06/05/2008	20690372

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	06/11/2008	06/11/2008

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## **Disposition**

Disposition Date: 06/11/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Summary of Variables	Approved-Closed	Yes
<b>Form</b>	Group Accidental Injury Policy	Approved-Closed	Yes
<b>Form</b>	Group Accidental Injury Certificate	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** HMP-ACC 308

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HMP-ACC 308	Policy/Cont ract/Fratern al Certificate	Group Accidental Injury Policy	Initial		56	Microsoft Word - HMP-ACC 308 - Policy 5..pdf
Approved-Closed	HMC-ACC 308	Certificate	Group Accidental Injury Certificate	Initial		51	Microsoft Word - HMC-ACC 308 - Cert 5..pdf



# HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

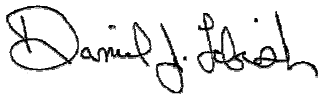
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POLICYHOLDER:	[*]
[PARTICIPATING ORGANIZATION]	[*]
POLICY NUMBER:	[*]
POLICY EFFECTIVE DATE:	[*]
POLICY ANNIVERSARY DATE:	[*]
STATE OF ISSUE:	[*]

**HM Life Insurance Company**, herein called the Company or we, us or our, in consideration of the [Application for this Policy, if any, and the] timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the [Policyholder]'s eligible [employee]s and their eligible dependents under this Policy. The [Policyholder] may add new [employee]s or dependents from time to time in accordance with the terms of the Policy. Subsequent anniversaries of the Policy will be the same date each year thereafter.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Policy. We and the [Policyholder] agree to all of the terms of this Policy

IN WITNESS WHEREOF **HM Life Insurance Company** has caused this Policy to be executed on the Date of Issue to take effect on the Effective Date.



**President**



**Secretary**

## GROUP ACCIDENTAL INJURY POLICY • NON-PARTICIPATING

### Questions or Comments

We want to hear from you. If you have any questions about this Policy, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Policy. Thank you for your loyal patronage.

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## [SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Policy on the effective dates listed below. A newly-acquired Affiliate may be covered under this Policy on the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

<b>[Affiliate Name</b>	<b>Location</b>	<b>Effective Date</b>
[*]	[*]	[*] ]

## SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Unless otherwise stated in this Policy, benefits are payable per Covered Person per Covered Accident. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [The period determined by the [Policyholder's] personnel practices]]

[For [employee]s hired after the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [the [Policyholder]'s next Open Enrollment Period] [The period determined by the [Policyholder's] personnel practices] ]

<b>Benefit</b>	<b>Scheduled Amount</b>		
<b>Accidental Injury</b>	<b>Plan 1</b>	<b>Plan 2</b>	<b>Plan 3</b>
<b>[Fractures</b>			
Hip/thigh	\$2,000	\$4,000	\$6,000
Vertebrae	\$1,800	\$3,600	\$5,400
Pelvis	\$1,600	\$3,200	\$4,800
Skull (depressed)	\$1,500	\$3,000	\$4,500
Skull (simple)	\$700	\$1,400	\$2,100
Leg	\$1,200	\$2,400	\$3,600
Foot/ankle/knee cap	\$1,000	\$2,000	\$3,000
Forearm/hand	\$1,000	\$2,000	\$3,000
Lower jaw	\$800	\$1,600	\$2,400
Shoulder blade/collar bone	\$800	\$1,600	\$2,400
Upper arm/upper jaw	\$700	\$1,400	\$2,100
Facial bones (except teeth)	\$600	\$1,200	\$1,800
Vertebral processes	\$400	\$800	\$1,200
Coccyx/rib/finger/toe	\$160	\$320	\$480
Wrist/Elbow	\$1000	\$2000	\$3000]
<b>[Dislocations</b>			
Hip	\$1,350	\$2,700	\$4,050
Knee (not knee cap)	\$950	\$1,900	\$2,850
Shoulder	\$750	\$1,500	\$2,250
Ankle	\$600	\$1,200	\$1,800
Lower jaw	\$450	\$900	\$1,350

Wrist	\$375	\$750	\$1,125	
Elbow	\$300	\$600	\$900	
Finger/toe	\$120	\$240	\$360]	
<b>[Lacerations</b>				
Over 6"	\$200	\$400	\$600	
2" to 6"	\$100	\$200	\$300	
Under 2"	\$50	\$100	\$150]	
[Lacerations not requiring stitches	\$25	\$50	\$75]	]
<b>[Concussions</b>				
	\$50	\$100	\$150]	
<b>[Coma</b>				
	\$2,500	\$5,000	\$7,500]	
<b>[Emergency Dental Work</b>				
	\$50	\$100	\$150]	
<b>[Injuries Requiring Surgery</b>				
[Eye injuries				
Requiring surgical repair	\$125	\$250	\$375	
Removal of foreign body	\$25	\$50	\$75]	
[Tendons/ligaments				
	\$200	\$400	\$600]	
[Ruptured disc				
	\$100	\$200	\$300]	
[Torn knee cartilage				
	\$100	\$200	\$300]	
[Internal Injuries				
	\$500	\$1,000	\$1,500]	
[Exploratory Surgery (without repair)				
	\$125	\$250	\$375]	]
<b>[Paralysis</b>				
Four limbs (quadriplegia)	\$5000	\$10,000	\$15,000	
Two limbs (paraplegia)	\$2,500	\$5,000	\$7,500]]	
<b>[Burns</b>				
[Second Degree				
Less than 10%	\$100	\$200	\$300	
At least 10% but less than 25%	\$200	\$400	\$600	
At least 25% but less than 35%	\$500	\$1,000	\$1,500	
35% or more	\$1,000	\$2,000	\$3,000 ]	
[Third Degree				
Less than 10%	\$500	\$1,000	\$1,500	
At least 10% but less than 25%	\$3,000	\$6,000	\$9,000	
At least 25% but less than 35%	\$7,000	\$14,000	\$21,000	
35% or more	\$10,000	\$20,000	\$30,000 ]	]
<b>[Skin Graft</b>				
	25% of the applicable burn benefit]			]

**[Services**

[Blood/plasma	\$100	\$100	\$100]
[Ambulance	\$50	\$100	\$150]
[Air ambulance	\$250	\$500	\$750]
[Transportation			
Train or Plane	\$150	\$300	\$450
Bus	\$75	\$150	\$225
Maximum of 3 trips per [Plan] Year]			
[Family Member Lodging			
Per Night	\$50	\$100	\$150
Maximum	30 days per Covered Accident]		
[Medical fees			
Maximum per accident	\$50	\$100	\$150]
[Prosthesis	\$250	\$500	\$750]
[Appliances	\$50	\$100	\$150]
[Accident Follow-up Treatment			
Maximum	\$15	\$30	\$45
	6 treatments per Covered Accident]		
[Physician Therapy			
Maximum	\$15	\$30	\$45
	6 treatments per Covered Accident] ]		

**[Health Screening**

Benefit per test	\$50	\$50	\$50]
Maximum	Once per [12 month period] [Plan] Year]		

**[Hospital Admission**

Maximum	\$500	\$1,000	\$1,500
	Once per [Plan] Year]		

**[Daily In-Hospital Benefit**

Benefit per day	\$100	\$200	\$300
Maximum	365 days per Hospital Stay]		

**[Hospital Intensive Care**

Benefit per day	\$100	\$200	\$300
Maximum Benefit	30 days per Hospital Stay]		

**[Accidental Dismemberment**

Loss of hand, foot or sight			
Single loss	\$5,000	\$10,000	\$15,000
Double loss	\$15,000	\$30,000	\$45,000
Loss of one or more fingers or toes	\$500	\$1,000	\$1,500
Partial Amputation of finger or toe	\$100	\$200	\$300 ]

**[Accidental Death**

	\$15, 000	\$30,000	\$45, 000]
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**[Common Carrier Accidental Death**

	\$50,000	\$100,000	\$200,000]
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<b>[Catastrophic Accident</b>	\$50,000	\$100,000	\$200,000]
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**[Reduction Schedule**

	<b>[Employee]</b>	<b>[Spouse] [Domestic Partner]</b>	<b>[Child]</b>
Rate	50%	50%	50%
Attained Age	70	70	70]

**Minimum Participation Requirement** [5] [Employees] [and] [Dependents]

**Rates and Premiums**

**Mode of Premium Payment** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual]

**Premium Due Dates** [Policy Effective Date and the first day of each month  
thereafter]

[Policy Effective Date and the first day of each calendar  
quarter thereafter]

Policy Effective Date and the first day [July] [and]  
[January] thereafter]

**Contributions** The [entire] cost of this insurance is paid by  
[the] [[Policyholder]] [and] [Covered Persons].

**Rates** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual] Rate

	<u>24-Hour</u>	<u>Non-Occupational</u>
[Employee]	[*]	[*]
[Employee] and Dependent Child(ren)	[*]	[*]
[[Employee] and [Dependent Spouse] [Domestic Partner] ]	[*]	[*]
[Family]	[*]	[*]
[Composite]	[*]	[*]

**DEFINITIONS**

Please note that certain words used in this Policy have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Policy have the meanings set forth below.

**Active Service** means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a[  
scheduled] basis, either at one of the [Employer's] usual places of business or at some other location  
to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][,  
only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an In-Patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care  
facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform

his regular duties on a scheduled basis;

2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

**Affiliate or Affiliated** means a company, location or division while subsidiary to, affiliated with or controlled by the [Policyholder].

**Certificate** means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

**Company or we, us, our,** means HM Life Insurance Company, domiciled in Pennsylvania.

**Covered Accident** means an Injury, which:

1. occurs as a result of an accident while the Covered Person is insured under the Policy, and after any applicable Eligibility Waiting Period; and
2. is not otherwise excluded under the terms of this Policy.

**[Employee]** means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- |   |           |  |
|---|-----------|--|
| [ | [Class 1] | [All [employee]s] of the [Policyholder] who are officers]                |
|   | [Class 2] | [All [employee]s] of the [Policyholder] who are managers or supervisors] |
|   | [Class 3] | [All [employee]s] of the [Policyholder]] at [location] ]                 |
|   | [Class 4] | All other [employee]s] of the [Policyholder]]]                           |

**Covered Person** means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

**Dependent** means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Policy; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Policy; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Policy and who:
  - [a.] is less than [19] [23] [25] [30] years old; or
  - [b.] is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
  - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered Employee's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19;

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

**[Domestic Partner]** means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][:;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][:;]
- [3.] [Is not currently registered in a domestic partnership with a different domestic partner and has not been in such a relationship for at least six months][:;]
- [4.] [occupies the same residence as the [Employee]][:;]
- [5.] [has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature][:;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]]. ]

**[Domestic Partnership Arrangement]** means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

- 1. joint lease, mortgage or deed;
- 2. joint ownership of a vehicle;
- 3. joint ownership of a checking account or credit account;
- 4. designation of the domestic partner as a beneficiary for the employee's life insurance or retirement benefits;
- 5. designation of the domestic partner as a beneficiary of the employee's will;
- 6. designation of the domestic partner as holding power of attorney for health care; or
- 7. shared household expenses. ]

**Eligibility Waiting Period** means the period of time that must lapse before an [Employee][,] [or] [Dependent] [or] [Domestic Partner] is eligible for this insurance. It will be extended by the number of days the [Employee] is not in Active Service. We will not pay benefits for an Injury or Injuries sustained during the Eligibility Waiting Period-

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [and] [Domestic Partner] [Covered Person] must [upon request] [and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[:;]



- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
- 3. provide any additional reasonable information about his insurability that we request; and
- 4. undergo a physical examination and testing at our request]. ]

**He, him or his** means an individual, male or female.

**Hospital** means an institution that meets all of the following:

- 1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
- 2. it is managed under the supervision of a staff of legally licensed physicians;
- 3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
- 4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
- 5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

- 1. rehabilitation, convalescent or custodial care; or
- 2. the aged.

**Hospital Intensive Care Unit** means a place which:

- 1. is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- 2. is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- 3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- 4. is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty four hour basis; and
- 5. has a doctor assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care unit is not any of the following step down units:

- 1. a progressive care unit;
- 2. a sub-acute intensive care unit;
- 3. an intermediate care unit;
- 4. a private monitored room;
- 5. a surgical recovery room;

6. an observation unit; or
7. any facility not meeting the definition of a hospital intensive care unit as defined in this Policy.

**Hospital Stay** means a confinement in a Hospital, ordered by a Physician or Doctor for at least 24 consecutive hours when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident or a Covered Sickness. Separate Hospital Stays due to the same Covered Accident or Covered Sickness will be treated as one Hospital Stay unless [(a)] separated by at least [30] [60] [90] days [or (b) a Covered [Employee] returns to Active Service for [15] [30] [45] or more days] between Hospital Stays.

**Immediate Family** - means your spouse, son, daughter, mother, father, sister or brother.

**Injury or Injuries** means bodily injury solely due to a Covered Accident. It includes all complications of and all injuries received from the same accident.

**In-Patient** means confinement [overnight] [,] [for at least] [one full day] [or] [twenty-four (24)] continuous hours for Treatment of a medical condition in a Hospital.

**[Occupational Benefits]** means benefits will be paid if an Injury occurs due to a Covered Accident while a Covered Person is working at any job for pay or benefits.]

**Open Enrollment Period** means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

**Out-Patient** means treatment received for a medical condition while not confined as an In-Patient in a Hospital.

**Physician or Doctor** means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder];
2. living in the Covered Person's household; or
3. a parent, sibling, spouse[,], [domestic partner] or child of the Covered Person.

**[Plan] Year or annual or annually** means a period of twelve consecutive months beginning on the Policy Effective Date and subsequent Anniversary Dates.

**Policyholder** means the entity shown on the cover page of this Policy.

**[Participating Organization]** means the entity shown on the cover page of this Policy.]

**Treatment or Medical Treatment** means care, services or supplies, provided by or at the direction of a Physician or Doctor that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury or sickness and are provided during the course of treatment of an Injury sustained in a Covered Accident.

## ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

### Policy Effective Date

We agree to provide the Accidental Injury benefits described in this Policy in consideration of the payment of the premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

### [Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]s of an Affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.]

### Eligibility

An [Employee][,][ Dependent] [or][ Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][ Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Policy as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

### Effective Date

The Effective Date of the Policy and Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

- [1.] submits a complete enrollment form, if any [and we approve that form]; and]
- [2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

- [1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form]][, and]
- [2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and
2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

### **Deferred Effective Date**

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible. Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

### **Late Enrollee**

A person will be considered a late enrollee if he does not apply for insurance under this Policy within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

## Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Policy or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

## Termination of Insurance

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Policy or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation approved by us; and
- [6.] with respect to an eligible [Dependent] [Domestic Partner], the [day] [first of the month] following the date of the death of the [Employee] or the [day] [first of the month] following the date of divorce from the [Employee][, or termination of a Domestic Partnership Arrangement] .

Termination will not affect a claim for a Covered Accident incurred after the Eligibility Waiting Period, if any, and while coverage was in effect.

## BENEFITS

The Scheduled Amount payable [for the plan selected] is shown in the *Schedule of Benefits*; unless otherwise noted the amount shown in the Schedule of Benefits is the full amount payable per Covered Person for the benefit, and payable once per Covered Person per Covered Accident. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### Accidental Injury Benefits

**[Fractures** – A fracture is a break in a bone which can be seen by X-ray or other imagining technology that is approved for such use. If a Covered Person fractures a bone in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the Injury, we will pay the amount shown in the *Schedule of Benefits*.

If the fracture requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Multiple Fractures** – If more than one fracture requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured which has the highest benefit amount payable.]

**[Chip Fracture** - A chip fracture is a piece of bone which is completely broken off near a joint. If a Physician diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown in the *Schedule of Benefits* for the affected bone.]

**[Dislocation –** A dislocation is a completely separated joint. If a Covered Person dislocates a joint in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the accident, we will pay the amount shown in the *Schedule of Benefits*.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Recurring Dislocations –** We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If a joint was dislocated before the effective date of a Covered Person insurance under the Certificate and such person dislocates the same joint again, it will not be covered by the Certificate.]

**[Multiple Dislocations –** If more than one dislocation requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each dislocation. However, we will pay no more than 200% of the benefit amount for the joint dislocated which has the highest benefit amount payable.]

**[Partial Dislocation –** A partial dislocation is one in which the joint is not completely separated. If a Physician or Doctor diagnoses and treats the Injury as a partial dislocation, we will pay 25% of the amount shown in the *Schedule of Benefits* for the affected joint.]

**[Fracture and Dislocation –** If a Covered Person fractures a bone, and dislocates a joint in the same Injury, we will pay for both; however, we will pay no more than 200% of the benefit amount for the bone fractured or joint dislocated, which has the highest benefit amount payable.]

**[Lacerations –** If a Covered Person receives a laceration in a Covered Accident and the laceration is repaired with stitches by a Physician or Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the *Schedule of Benefits*. The benefit amount paid will be based on the length of the laceration.

[If a Covered Person receives a laceration in a Covered Accident and the laceration does not require stitches but is treated by a Physician or Doctor within 72 after the accident, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

If a Covered Person suffers multiple lacerations in a Covered Accident and the lacerations are repaired with [or without] stitches by a Physician or Doctor within 72 hours after the Injury, we will pay this benefit based on the largest single laceration as shown in the *Schedule of Benefits*.

As used above “stitches” means stitches, sutures or medical adhesive.]

**[Concussion –** If a Covered Person sustains a concussion as the result of Injuries received in a Covered Accident we will pay the amount shown in the *Schedule of Benefits*. The Covered Person must be diagnosed by a Physician or Doctor within 72 hours after the date of the Covered Accident using any type of medical imaging procedures (CAT scans, MRI, and/or X-ray are examples of medical imaging procedures).]

**[Coma –** If a Covered Person suffers a coma lasting [15] [30] days or more as the result of a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Coma means a profound state of unconsciousness caused by a Covered Accident that lasts for a period of 24 to 48 consecutive hours from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician or Doctor. The Diagnosis of Coma must indicate that permanent neurological deficit is present.]

**[Emergency Dental Work –** We will pay the amount shown in the *Schedule of Benefits* if a Covered Person receives an Injury to sound natural teeth as the result of a Covered Accident.]

## **[Injuries Requiring Surgery]**

**[Eye Injuries –** If a Covered Person injures an eye (or eyes) in a Covered Accident and surgical repair is performed by a Physician or Doctor within 90 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* per eye. If a Physician or Doctor removes a foreign body from a Covered Person's eye, with or without anesthesia, we will pay the amount shown in the *Schedule of Benefits*.]

**[Tendons and Ligaments –** If a Covered Person tears, severs or ruptures a tendon or ligament in a Covered Accident, receives treatment from a Physician or Doctor within 60 days, and has surgical repair within 90 days after the Injury we will pay the appropriate amount shown in the *Schedule of Benefits*. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

If multiple of tendons or ligaments repaired we will pay no more than 200% of the benefit amount shown in the *Schedule of Benefits*.

If a Covered Person is in a Covered Accident and fractures a bone or dislocates a joint, and tears, severs or ruptures a tendon or ligament, we will pay only one benefit. We will pay the largest of the fracture benefit, the Dislocation Benefit, or the Tendon and Ligament Benefit shown in the *Schedule of Benefits*.]

**[Ruptured Disc –** If a Covered Person ruptures a disc in their spine in a Covered Accident, receives treatment from a Physician or Doctor within 60 days after the accident and has surgical repair by a Physician or Doctor within one year after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Torn Knee Cartilage –** We will pay this benefit in the amount shown in the *Schedule of Benefits* if a Covered Person is injured in a Covered Accident and:

1. the Injury resulted in torn knee cartilage;
2. such Injury requires treatment by a Physician or Doctor within 60 days from the date of the Covered Accident; and
3. such Injury requires repair by surgical operation within 365 days from the date of the Covered Accident.]

**[Internal Injuries –** We will pay this benefit as shown in the *Schedule of Benefits* if a Covered Person has internal injuries as the result of a Covered Accident which results in open abdominal or thoracic surgery.]

**[Exploratory Surgery –** If as the result of an Injury in a Covered Accident a Covered Person has exploratory surgery (without repair), we will pay the amount shown on the *Schedule of Benefits*. The Covered Person must have such surgery within 72 hours after the date of the Covered Accident.] ]

**[Paralysis –** Paralysis means the permanent loss of movement of two or more limbs. If a Covered Person is injured in a Covered Accident and the Injury causes paralysis which lasts more than 90 days and is diagnosed by a Physician within 90 days after the Injury, we will pay:

1. The appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee].
2. 50% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Dependent spouse] [Domestic Partner]; and
3. 25% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the Covered Person later dies as a result of the same Covered Accident, we will pay the appropriate Death Benefit or Catastrophic Accident Benefit, less any amounts paid under the Paralysis Benefit.]

**[Burns –** If a Covered Person is burned in a Covered Accident and treated by a Physician or Doctor within 72 hours after the Injury, we will pay the Burn Benefit shown in the *Schedule of Benefits* according to the percentage of body surface burned.

If the Covered Person meets more than one of the burn classifications shown in the *Schedule of Benefits* we will pay the higher amount. We will pay only one of the classification amounts once per Covered Person per Covered Accident.

First degree burns are not covered.]

**[Skin Graft –** If a Covered Person receives a skin graft for a burn for which a benefit was received under the Burn Benefit we will pay the Skin Graft Benefit shown in the *Schedule of Benefits*. We will pay only one of the classification amounts once per Covered Person per Covered Accident.]

### **[Services**

**[Blood/Plasma –** If a Covered Person is injured in a Covered Accident we will pay the amount shown in the *Schedule of Benefits* for blood, plasma or other blood products received within 90 days of the Injury.]

**[Ambulance –** If a Covered Person is injured in a Covered Accident and requires transportation to a Hospital by a professional ambulance service (including "air ambulance" service) within 90 days after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Transportation –** We will pay this benefit if a Covered Person is injured in a Covered Accident and the Injury causes the attending Physician or Doctor to recommend hospital treatment or diagnostic study, which is not available in the city where the Covered Person resides. We will pay the applicable amount shown in the *Schedule of Benefits* for transportation by train, plane, or bus for each Covered Accident. Use of such transportation must begin within 90 days from the date of the Covered Accident. The distance to the location of the hospital treatment or diagnostic study must be greater than 50 miles from the Covered Person's residence.]

**[Family Member Lodging –** We will pay this benefit in amount and for the number of days shown in the *Schedule of Benefits*, for each night's lodging in a Motel/Hotel room for an adult member of the Covered Person's Immediate Family during a Hospital Stay to treat a Covered Person for an Injury due to a Covered Accident.

The Hospital and Motel/Hotel must be more than 100 miles from the Covered Person's residence. The treatment must be prescribed by the Covered Person's local Physician.]

**[Medical Fees –** If a Covered Person is injured in a Covered Accident and receives treatment within 365 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* for:

1. emergency room services and supplies;
2. X-rays;
3. Physician services.



We will pay for these services up to the total amount shown for Medical Fees in the *Schedule of Benefits*, for each Covered Accident.

This benefit is payable if a Covered Person receives initial treatment within 60 days after the Injury.]

**[Prosthesis –** We will pay the amount shown in the *Schedule of Benefits* for each prosthetic device a Covered Person uses as the result of an Injury received in a Covered Accident. Artificial joints, hearing aids, wigs, or dental aids including but not limited to false teeth are not covered.]

**[Appliances –** If a Covered Person is advised by a Physician or Doctor to use a medical appliance as an aid in personal locomotion as the result of an injury received in a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Medical appliance means crutches, wheelchairs, leg braces, back braces and walkers.]

**[Accident Follow-up Treatment –** We will pay the amount shown in the *Schedule of Benefits* when a Covered Person receives follow-up treatment for an Injury received as a result of a Covered Accident. We will pay for a total of six treatments per Covered Accident. You must have received initial treatment within 72 hours of a Covered Accident and follow-up treatment must begin within 30 days of the Covered Accident or discharge from the hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Out-Patient basis.]

**[Physical Therapy –** If a Covered Person is injured in a Covered Accident and that Injury requires physical therapy, we will pay the amount shown in the *Schedule of Benefits* for a maximum of six physical therapy sessions per Covered Accident. A Covered Person must have received initial treatment for the Injury within 72 hours of the Covered Accident and physical therapy must begin within 30 days of the Injury or discharge from the Hospital. All physical therapy sessions for such accident must take place within six months of the Injury or discharge from the Hospital. We will not pay this benefit for the same visit that the Accident Follow-up Treatment benefit is paid.] ]

### **[Health Screening Benefit**

After a Covered Person has been continuously insured for 12 months, we will pay the amount shown in the *Schedule of Benefits* for the Health Screening Tests. This Benefit is payable once [in any 12 month period] [per [Plan] Year].

As used above "Health Screening Test" means:

1. Stress test on a bicycle or treadmill, or using Thallium or similar pharmaceutical agent;
2. Fasting blood glucose test;
3. Blood test for triglycerides;
4. Serum cholesterol test to determine level of HDL and LDL;
5. Bone marrow testing;
6. Breast ultrasound;
7. CA 15-3 (blood test for breast cancer);
8. CA 125 (blood test for ovarian cancer);
9. CEA (blood test for colon cancer);
10. Chest X-ray;
11. Colonoscopy;

12. Flexible sigmoidoscopy;
13. Hemocult stool analysis;
14. Mammography;
15. Pap test;
16. PSA (blood test for prostate cancer);
17. Serum Protein Electrophoresis (blood test for myeloma);
18. Thermography; and
19. Skin review by a dermatologist.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.]

### **[Hospital Benefit**

**Hospital Admission** – We will pay this benefit when a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay within six months of the date of the Injury.

We will pay the Hospital Admission Benefit amount shown in the *Schedule of Benefits*. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

We will pay this benefit once per Hospital Stay.

**Daily In-Hospital Benefit** – If a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay [within 90][365] days] after the Injury, we will pay the amount shown in the *Schedule of Benefits* for each day that you are confined to a Hospital. The length of time shown for Hospital Confinement in the *Schedule of Benefits* is the Maximum Period for which you can collect benefits for Hospital Confinements resulting from the same injury.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.

**[Hospital Intensive Care** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to be confined to a Hospital Intensive Care Unit during a Hospital Stay, we will pay the amount shown in the *Schedule of Benefits* for the number of days shown in the *Schedule of Benefits* per Covered Accident. This benefit is payable in addition to the Daily In-Hospital Benefit above.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.] ]

### **[Dismemberment Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes loss of a hand, foot or sight within 90] 365] days after the Injury we will pay:

1. The amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];

3. 25% of the amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

If a Covered Person loses one hand, one foot or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the *Schedule of Benefits*.

“Dismemberment” means:

1. loss of a hand: the hand is cut off at or above the wrist joint;
2. loss of a foot: the foot is cut off at or above the ankle;
3. loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; or
4. loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If a Covered Person does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment shown in the *Schedule of Benefits*.

If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under this benefit.]

#### **[Accidental Death Benefit**

**Accidental Death** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

[If the Accidental Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.]

**[Accidental Common Carrier Death Benefit** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

To receive this benefit the injury must be the result of traveling as a fare-paying passenger on a Common Carrier, as defined below.

“Common Carrier” means:

1. an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
2. a railroad train which is licensed and operated for passenger service only; or
3. a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental Death Benefit.]

### **[Catastrophic Accident Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes a Catastrophic Loss within 365 days after the Injury, we will pay:

1. The amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The Catastrophic Accident Benefit is payable once per lifetime for each Covered Person.

“Catastrophic Loss” means an Injury, which results in total and irrecoverable:

1. loss of both hands or both feet;
2. loss of both arms or both legs;
3. loss of use of both arms or both legs;
4. loss of one hand and one foot;
5. loss of one arm and one leg;
6. loss of use of one arm and one leg;
7. Total Blindness;
8. loss of the hearing of both ears; or
9. loss of the ability to speak.

The loss of use of an arm means the loss of function of the entire arm from the shoulder to the fingers.

The loss of use of the leg means the loss of function of the entire leg from the hip to the toes.

The loss of hearing means deafness in both ears, meaning best corrected hearing threshold of 90 dB or greater in the better ear, and such that it cannot be corrected to any functional degree by any procedure, aid or device.

The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

[If a Paralysis or Dismemberment Benefit is paid and the Covered Person is eligible for a Catastrophic Accident Benefit as a result of the same Covered Accident, we will pay the appropriate Catastrophic Accident Benefit, less any amounts paid under the Paralysis or Dismemberment Benefit.]

[If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Accidental Death Benefit, less any amounts paid under this benefit.] ]

## **LIMITATIONS AND EXCLUSIONS**

### **Limitations**

- [1.] Eligibility Waiting Period – No benefits are payable for any Covered Person until the Eligibility Waiting Period shown has been completed. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
- [2.] Reduction Schedule – The Payment Level for the Scheduled Amount payable will be reduced by 50% if a Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

### **Exclusions**

We will not pay benefits for loss contributed to, caused by, or resulting from the following unless specifically provided elsewhere in this Policy:

1. Loss due to sickness, or any benefit for a diagnosis caused or contributed to by a sickness, except as described in *Health Screening Benefits*;
2. Rest care or custodial care and any associated transportation;
3. Dental, eye or hearing care other than those resulting from a Covered Accident;
4. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury [, unless as a result of a medical condition or an act of domestic violence];
5. Loss due to an Injury while participating in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
6. Loss due to an Injury while committing, attempting to commit, or taking part in a felony or assault;
7. Loss due to an Injury while participating in a contest of speed in power driven vehicles or a self propelled conveyance, parachuting, parasailing, bungee jumping, mountain climbing, spelunking, or hang gliding, operating an all terrain vehicle (ATV or dirt bike), SCUBA diving, white water rafting or mountain biking;
8. Loss for Injury while participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received.

9. Loss occurring during air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route
  - b. on a charter flight operated by a scheduled airline; or
  - c. as a passenger for transportation only and not as a pilot or crew member;
10. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
11. Loss due to an Injury resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not provided by or at the direction of a Physician or Doctor;
12. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an Injury occurring or contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
13. Loss due to an Injury arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
14. Loss due to an Injury while driving any taxi, or long-distance or other commercial vehicle in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made.
15. Loss due to an Injury during a period of time that insurance for a Covered Person is not in force;
16. Loss due to an Injury after this Policy has terminated;
17. Loss due to an Injury not provided by or at the direction of a Physician or Doctor, or is inconsistent with standards of medical practice for the applicable condition;
18. Treatment of any Injury outside the United States or Canada;
19. Rendered by any person who is:
  - a. employed or retained by the [Policyholder];
  - b. living in the Covered Person's household;
  - c. a parent, sibling, spouse[,], [domestic partner] or child of a Covered [Employee] or of his spouse; or
  - d. a Covered Person treating himself.

## **CLAIM PROVISIONS**

### **Notice of Claim**

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Covered Accident is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name and the Covered Person's name, address, Policy and Policy Number.

## **Claim Forms**

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

## **Proof of Loss**

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

## **[Notice of Decision**

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

**Review Of Denied Claims** – For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours. ]

### **Time of Payment of Claims**

We will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

### **Payment of Claims**

All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person. Any benefits unpaid at the time of a Covered Person's death will be paid in the following order:

1. to any approved assignee;
2. the Covered Person's beneficiary;
3. a Covered Person's surviving spouse;
4. a Covered Person's estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

### **Change of Beneficiary**

A Covered [Employee] may ask us to change his beneficiary at any time. [The request must be in writing and the change must be approved by us.] If approved, it will go into effect the day the Covered Person signs the request. The change will not have any bearing on payments made before we approved the request.

### **Claimant Cooperation Provision**

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

### **Claim Administration**

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of



fact. All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

### **Payment of Claims to Foreign [Employees]**

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Policy.

### **Physical Examination and Autopsy**

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

### **Legal Actions**

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

### **Recovery of Overpayment**

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

### **[Additional Coverage with the Company]**

We will only pay benefits for a Covered Accident under one Accidental Injury Policy or Certificate if a Covered Person is covered by more than one of our Accidental Injury Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Accidental Injury Policies or Certificates during the period there was more than one Policy or Certificate in force.]

**Unpaid Premium** – When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

## **ADMINISTRATIVE PROVISIONS**

### **Cancellation**

We or the [Policyholder] may cancel this Policy, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination

### **Grace Period**

A Policy Grace Period of [31] [60] [90] days will be granted for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by the Certificate beyond the period for which premium has been accepted; and
2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Policy was in force.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

### **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

### **Premium Payment**

The total premium for this Policy is the sum of premiums paid by the [Policyholder] for all Covered Persons below, including any amounts contributed toward the cost of this coverage by Covered Persons. If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

### **Changes in Premium Rates**

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the number of Covered Persons eligible for coverage increases or decreases by more than 10% since the latter of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;

4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Policy; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

### **Premium Audit**

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

## **GENERAL PROVISIONS**

### **Entire Contract; Changes**

This Policy, including the [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

### **Misstatement of Age**

If an age has been misstated on the enrollment form, the Benefits will be those the premium paid would have purchased at the correct age.

### **Certificates**

Where required by law, we will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

### **Assignment**

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

### **Incontestability**

#### **1. Of This Policy**

All statements made by the [Policyholder] to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

## 2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

### **Reporting Requirements**

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

### **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, we will adjust the premium fairly.

### **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Compensation Insurance**

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

# HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

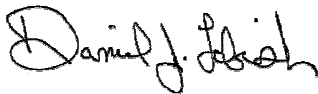
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POLICYHOLDER:	[*]
[PARTICIPATING ORGANIZATION]	[*]
POLICY NUMBER:	[*]
POLICY EFFECTIVE DATE:	[*]
POLICY ANNIVERSARY DATE:	[*]
STATE OF ISSUE:	[*]

**HM Life Insurance Company**, herein called the Company or we, us or our, in consideration of the [Application for this Policy, if any, and the] timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the [Policyholder]'s eligible [employee]s and their eligible dependents under this Policy. The [Policyholder] may add new [employee]s or dependents from time to time in accordance with the terms of the Policy. Subsequent anniversaries of the Policy will be the same date each year thereafter.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Policy. We and the [Policyholder] agree to all of the terms of this Policy

IN WITNESS WHEREOF **HM Life Insurance Company** has caused this Policy to be executed on the Date of Issue to take effect on the Effective Date.



**President**



**Secretary**

## GROUP ACCIDENTAL INJURY POLICY • NON-PARTICIPATING

### Questions or Comments

We want to hear from you. If you have any questions about this Policy, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Policy. Thank you for your loyal patronage.

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## [SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Policy on the effective dates listed below. A newly-acquired Affiliate may be covered under this Policy on the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

<b>[Affiliate Name</b>	<b>Location</b>	<b>Effective Date</b>
[*]	[*]	[*] ]

## SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Unless otherwise stated in this Policy, benefits are payable per Covered Person per Covered Accident. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [The period determined by the [Policyholder's] personnel practices]]

[For [employee]s hired after the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [the [Policyholder]'s next Open Enrollment Period] [The period determined by the [Policyholder's] personnel practices] ]

<b>Benefit</b>	<b>Scheduled Amount</b>		
<b>Accidental Injury</b>	<b>Plan 1</b>	<b>Plan 2</b>	<b>Plan 3</b>
<b>[Fractures</b>			
Hip/thigh	\$2,000	\$4,000	\$6,000
Vertebrae	\$1,800	\$3,600	\$5,400
Pelvis	\$1,600	\$3,200	\$4,800
Skull (depressed)	\$1,500	\$3,000	\$4,500
Skull (simple)	\$700	\$1,400	\$2,100
Leg	\$1,200	\$2,400	\$3,600
Foot/ankle/knee cap	\$1,000	\$2,000	\$3,000
Forearm/hand	\$1,000	\$2,000	\$3,000
Lower jaw	\$800	\$1,600	\$2,400
Shoulder blade/collar bone	\$800	\$1,600	\$2,400
Upper arm/upper jaw	\$700	\$1,400	\$2,100
Facial bones (except teeth)	\$600	\$1,200	\$1,800
Vertebral processes	\$400	\$800	\$1,200
Coccyx/rib/finger/toe	\$160	\$320	\$480
Wrist/Elbow	\$1000	\$2000	\$3000]
<b>[Dislocations</b>			
Hip	\$1,350	\$2,700	\$4,050
Knee (not knee cap)	\$950	\$1,900	\$2,850
Shoulder	\$750	\$1,500	\$2,250
Ankle	\$600	\$1,200	\$1,800
Lower jaw	\$450	\$900	\$1,350

Wrist	\$375	\$750	\$1,125	
Elbow	\$300	\$600	\$900	
Finger/toe	\$120	\$240	\$360]	
<b>[Lacerations</b>				
Over 6"	\$200	\$400	\$600	
2" to 6"	\$100	\$200	\$300	
Under 2"	\$50	\$100	\$150]	
[Lacerations not requiring stitches	\$25	\$50	\$75]	]
<b>[Concussions</b>				
	\$50	\$100	\$150]	
<b>[Coma</b>				
	\$2,500	\$5,000	\$7,500]	
<b>[Emergency Dental Work</b>				
	\$50	\$100	\$150]	
<b>[Injuries Requiring Surgery</b>				
[Eye injuries				
Requiring surgical repair	\$125	\$250	\$375	
Removal of foreign body	\$25	\$50	\$75]	
[Tendons/ligaments				
	\$200	\$400	\$600]	
[Ruptured disc				
	\$100	\$200	\$300]	
[Torn knee cartilage				
	\$100	\$200	\$300]	
[Internal Injuries				
	\$500	\$1,000	\$1,500]	
[Exploratory Surgery (without repair)				
	\$125	\$250	\$375]	]
<b>[Paralysis</b>				
Four limbs (quadriplegia)	\$5000	\$10,000	\$15,000	
Two limbs (paraplegia)	\$2,500	\$5,000	\$7,500]]	
<b>[Burns</b>				
[Second Degree				
Less than 10%	\$100	\$200	\$300	
At least 10% but less than 25%	\$200	\$400	\$600	
At least 25% but less than 35%	\$500	\$1,000	\$1,500	
35% or more	\$1,000	\$2,000	\$3,000 ]	
[Third Degree				
Less than 10%	\$500	\$1,000	\$1,500	
At least 10% but less than 25%	\$3,000	\$6,000	\$9,000	
At least 25% but less than 35%	\$7,000	\$14,000	\$21,000	
35% or more	\$10,000	\$20,000	\$30,000 ]	]
<b>[Skin Graft</b>				
	25% of the applicable burn benefit]			]



**[Services**

[Blood/plasma	\$100	\$100	\$100]
[Ambulance	\$50	\$100	\$150]
[Air ambulance	\$250	\$500	\$750]
[Transportation			
Train or Plane	\$150	\$300	\$450
Bus	\$75	\$150	\$225
Maximum of 3 trips per [Plan] Year]			
[Family Member Lodging			
Per Night	\$50	\$100	\$150
Maximum	30 days per Covered Accident]		
[Medical fees			
Maximum per accident	\$50	\$100	\$150]
[Prosthesis	\$250	\$500	\$750]
[Appliances	\$50	\$100	\$150]
[Accident Follow-up Treatment			
Maximum	\$15	\$30	\$45
	6 treatments per Covered Accident]		
[Physician Therapy			
Maximum	\$15	\$30	\$45
	6 treatments per Covered Accident] ]		

**[Health Screening**

Benefit per test	\$50	\$50	\$50]
Maximum	Once per [12 month period] [Plan] Year]		

**[Hospital Admission**

Maximum	\$500	\$1,000	\$1,500
	Once per [Plan] Year]		

**[Daily In-Hospital Benefit**

Benefit per day	\$100	\$200	\$300
Maximum	365 days per Hospital Stay]		

**[Hospital Intensive Care**

Benefit per day	\$100	\$200	\$300
Maximum Benefit	30 days per Hospital Stay]		

**[Accidental Dismemberment**

Loss of hand, foot or sight			
Single loss	\$5,000	\$10,000	\$15,000
Double loss	\$15,000	\$30,000	\$45,000
Loss of one or more fingers or toes	\$500	\$1,000	\$1,500
Partial Amputation of finger or toe	\$100	\$200	\$300 ]

**[Accidental Death**

	\$15, 000	\$30,000	\$45, 000]
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**[Common Carrier Accidental Death**

	\$50,000	\$100,000	\$200,000]
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<b>[Catastrophic Accident</b>	\$50,000	\$100,000	\$200,000]
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**[Reduction Schedule**

	<b>[Employee]</b>	<b>[Spouse] [Domestic Partner]</b>	<b>[Child]</b>
Rate	50%	50%	50%
Attained Age	70	70	70]

**Minimum Participation Requirement** [5] [Employees] [and] [Dependents]

**Rates and Premiums**

**Mode of Premium Payment** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual]

**Premium Due Dates** [Policy Effective Date and the first day of each month  
thereafter]

[Policy Effective Date and the first day of each calendar  
quarter thereafter]

Policy Effective Date and the first day [July] [and]  
[January] thereafter]

**Contributions** The [entire] cost of this insurance is paid by  
[the] [[Policyholder]] [and] [Covered Persons].

**Rates** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual] Rate

	<u>24-Hour</u>	<u>Non-Occupational</u>
[Employee]	[*]	[*]
[Employee] and Dependent Child(ren)	[*]	[*]
[[Employee] and [Dependent Spouse] [Domestic Partner] ]	[*]	[*]
[Family]	[*]	[*]
[Composite]	[*]	[*]

**DEFINITIONS**

Please note that certain words used in this Policy have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Policy have the meanings set forth below.

**Active Service** means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a[  
scheduled] basis, either at one of the [Employer's] usual places of business or at some other location  
to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][,  
only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an In-Patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care  
facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform

his regular duties on a scheduled basis;

2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

**Affiliate or Affiliated** means a company, location or division while subsidiary to, affiliated with or controlled by the [Policyholder].

**Certificate** means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

**Company or we, us, our,** means HM Life Insurance Company, domiciled in Pennsylvania.

**Covered Accident** means an Injury, which:

1. occurs as a result of an accident while the Covered Person is insured under the Policy, and after any applicable Eligibility Waiting Period; and
2. is not otherwise excluded under the terms of this Policy.

**[Employee]** means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- |   |           |  |
|---|-----------|--|
| [ | [Class 1] | [All [employee]s] of the [Policyholder] who are officers]                |
|   | [Class 2] | [All [employee]s] of the [Policyholder] who are managers or supervisors] |
|   | [Class 3] | [All [employee]s] of the [Policyholder]] at [location] ]                 |
|   | [Class 4] | All other [employee]s] of the [Policyholder]]]                           |

**Covered Person** means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

**Dependent** means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Policy; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Policy; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Policy and who:
  - [a.] is less than [19] [23] [25] [30] years old; or
  - [b.] is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
  - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered Employee's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19;

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

**[Domestic Partner]** means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a domestic partnership with a different domestic partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]]. ]

**[Domestic Partnership Arrangement]** means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

- 1. joint lease, mortgage or deed;
- 2. joint ownership of a vehicle;
- 3. joint ownership of a checking account or credit account;
- 4. designation of the domestic partner as a beneficiary for the employee's life insurance or retirement benefits;
- 5. designation of the domestic partner as a beneficiary of the employee's will;
- 6. designation of the domestic partner as holding power of attorney for health care; or
- 7. shared household expenses. ]

**Eligibility Waiting Period** means the period of time that must lapse before an [Employee][,] [or] [Dependent] [or] [Domestic Partner] is eligible for this insurance. It will be extended by the number of days the [Employee] is not in Active Service. We will not pay benefits for an Injury or Injuries sustained during the Eligibility Waiting Period-

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [and] [Domestic Partner] [Covered Person] must [upon request] [and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]

- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
- 3. provide any additional reasonable information about his insurability that we request; and
- 4. undergo a physical examination and testing at our request]. ]

**He, him or his** means an individual, male or female.

**Hospital** means an institution that meets all of the following:

- 1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
- 2. it is managed under the supervision of a staff of legally licensed physicians;
- 3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
- 4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
- 5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

- 1. rehabilitation, convalescent or custodial care; or
- 2. the aged.

**Hospital Intensive Care Unit** means a place which:

- 1. is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- 2. is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- 3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- 4. is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty four hour basis; and
- 5. has a doctor assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care unit is not any of the following step down units:

- 1. a progressive care unit;
- 2. a sub-acute intensive care unit;
- 3. an intermediate care unit;
- 4. a private monitored room;
- 5. a surgical recovery room;

6. an observation unit; or
7. any facility not meeting the definition of a hospital intensive care unit as defined in this Policy.

**Hospital Stay** means a confinement in a Hospital, ordered by a Physician or Doctor for at least 24 consecutive hours when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident or a Covered Sickness. Separate Hospital Stays due to the same Covered Accident or Covered Sickness will be treated as one Hospital Stay unless [(a)] separated by at least [30] [60] [90] days [or (b) a Covered [Employee] returns to Active Service for [15] [30] [45] or more days] between Hospital Stays.

**Immediate Family** - means your spouse, son, daughter, mother, father, sister or brother.

**Injury or Injuries** means bodily injury solely due to a Covered Accident. It includes all complications of and all injuries received from the same accident.

**In-Patient** means confinement [overnight] [,] [for at least] [one full day] [or] [twenty-four (24)] continuous hours for Treatment of a medical condition in a Hospital.

**[Occupational Benefits]** means benefits will be paid if an Injury occurs due to a Covered Accident while a Covered Person is working at any job for pay or benefits.]

**Open Enrollment Period** means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

**Out-Patient** means treatment received for a medical condition while not confined as an In-Patient in a Hospital.

**Physician or Doctor** means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder];
2. living in the Covered Person's household; or
3. a parent, sibling, spouse[,], [domestic partner] or child of the Covered Person.

**[Plan] Year or annual or annually** means a period of twelve consecutive months beginning on the Policy Effective Date and subsequent Anniversary Dates.

**Policyholder** means the entity shown on the cover page of this Policy.

**[Participating Organization]** means the entity shown on the cover page of this Policy.]

**Treatment or Medical Treatment** means care, services or supplies, provided by or at the direction of a Physician or Doctor that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury or sickness and are provided during the course of treatment of an Injury sustained in a Covered Accident.

## ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

### Policy Effective Date

We agree to provide the Accidental Injury benefits described in this Policy in consideration of the payment of the premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

### [Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]s of an Affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.]

### Eligibility

An [Employee][,][ Dependent] [or][ Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
3. in the case of an [Employee][,][ Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]

[4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Policy as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

### Effective Date

The Effective Date of the Policy and Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

[1.] submits a complete enrollment form, if any [and we approve that form]; and]

[2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

[1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form]][,]  
[and]

[2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and
2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

### **Deferred Effective Date**

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible. Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

### **Late Enrollee**

A person will be considered a late enrollee if he does not apply for insurance under this Policy within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]



## Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Policy or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

## Termination of Insurance

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Policy or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation approved by us; and
- [6.] with respect to an eligible [Dependent] [Domestic Partner], the [day] [first of the month] following the date of the death of the [Employee] or the [day] [first of the month] following the date of divorce from the [Employee][, or termination of a Domestic Partnership Arrangement] .

Termination will not affect a claim for a Covered Accident incurred after the Eligibility Waiting Period, if any, and while coverage was in effect.

## BENEFITS

The Scheduled Amount payable [for the plan selected] is shown in the *Schedule of Benefits*; unless otherwise noted the amount shown in the Schedule of Benefits is the full amount payable per Covered Person for the benefit, and payable once per Covered Person per Covered Accident. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### Accidental Injury Benefits

**[Fractures** – A fracture is a break in a bone which can be seen by X-ray or other imaging technology that is approved for such use. If a Covered Person fractures a bone in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the Injury, we will pay the amount shown in the *Schedule of Benefits*.

If the fracture requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Multiple Fractures** – If more than one fracture requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured which has the highest benefit amount payable.]

**[Chip Fracture** - A chip fracture is a piece of bone which is completely broken off near a joint. If a Physician diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown in the *Schedule of Benefits* for the affected bone.]

**[Dislocation –** A dislocation is a completely separated joint. If a Covered Person dislocates a joint in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the accident, we will pay the amount shown in the *Schedule of Benefits*.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Recurring Dislocations –** We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If a joint was dislocated before the effective date of a Covered Person insurance under the Certificate and such person dislocates the same joint again, it will not be covered by the Certificate.]

**[Multiple Dislocations –** If more than one dislocation requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each dislocation. However, we will pay no more than 200% of the benefit amount for the joint dislocated which has the highest benefit amount payable.]

**[Partial Dislocation –** A partial dislocation is one in which the joint is not completely separated. If a Physician or Doctor diagnoses and treats the Injury as a partial dislocation, we will pay 25% of the amount shown in the *Schedule of Benefits* for the affected joint.]

**[Fracture and Dislocation –** If a Covered Person fractures a bone, and dislocates a joint in the same Injury, we will pay for both; however, we will pay no more than 200% of the benefit amount for the bone fractured or joint dislocated, which has the highest benefit amount payable.]

**[Lacerations –** If a Covered Person receives a laceration in a Covered Accident and the laceration is repaired with stitches by a Physician or Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the *Schedule of Benefits*. The benefit amount paid will be based on the length of the laceration.

[If a Covered Person receives a laceration in a Covered Accident and the laceration does not require stitches but is treated by a Physician or Doctor within 72 after the accident, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

If a Covered Person suffers multiple lacerations in a Covered Accident and the lacerations are repaired with [or without] stitches by a Physician or Doctor within 72 hours after the Injury, we will pay this benefit based on the largest single laceration as shown in the *Schedule of Benefits*.

As used above “stitches” means stitches, sutures or medical adhesive.]

**[Concussion –** If a Covered Person sustains a concussion as the result of Injuries received in a Covered Accident we will pay the amount shown in the *Schedule of Benefits*. The Covered Person must be diagnosed by a Physician or Doctor within 72 hours after the date of the Covered Accident using any type of medical imaging procedures (CAT scans, MRI, and/or X-ray are examples of medical imaging procedures).]

**[Coma –** If a Covered Person suffers a coma lasting [15] [30] days or more as the result of a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Coma means a profound state of unconsciousness caused by a Covered Accident that lasts for a period of 24 to 48 consecutive hours from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician or Doctor. The Diagnosis of Coma must indicate that permanent neurological deficit is present.]

**[Emergency Dental Work –** We will pay the amount shown in the *Schedule of Benefits* if a Covered Person receives an Injury to sound natural teeth as the result of a Covered Accident.]

## **[Injuries Requiring Surgery**

**[Eye Injuries –** If a Covered Person injures an eye (or eyes) in a Covered Accident and surgical repair is performed by a Physician or Doctor within 90 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* per eye. If a Physician or Doctor removes a foreign body from a Covered Person's eye, with or without anesthesia, we will pay the amount shown in the *Schedule of Benefits*.]

**[Tendons and Ligaments –** If a Covered Person tears, severs or ruptures a tendon or ligament in a Covered Accident, receives treatment from a Physician or Doctor within 60 days, and has surgical repair within 90 days after the Injury we will pay the appropriate amount shown in the *Schedule of Benefits*. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

If multiple of tendons or ligaments repaired we will pay no more than 200% of the benefit amount shown in the *Schedule of Benefits*.

If a Covered Person is in a Covered Accident and fractures a bone or dislocates a joint, and tears, severs or ruptures a tendon or ligament, we will pay only one benefit. We will pay the largest of the fracture benefit, the Dislocation Benefit, or the Tendon and Ligament Benefit shown in the *Schedule of Benefits*.]

**[Ruptured Disc –** If a Covered Person ruptures a disc in their spine in a Covered Accident, receives treatment from a Physician or Doctor within 60 days after the accident and has surgical repair by a Physician or Doctor within one year after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Torn Knee Cartilage –** We will pay this benefit in the amount shown in the *Schedule of Benefits* if a Covered Person is injured in a Covered Accident and:

1. the Injury resulted in torn knee cartilage;
2. such Injury requires treatment by a Physician or Doctor within 60 days from the date of the Covered Accident; and
3. such Injury requires repair by surgical operation within 365 days from the date of the Covered Accident.]

**[Internal Injuries –** We will pay this benefit as shown in the *Schedule of Benefits* if a Covered Person has internal injuries as the result of a Covered Accident which results in open abdominal or thoracic surgery.]

**[Exploratory Surgery –** If as the result of an Injury in a Covered Accident a Covered Person has exploratory surgery (without repair), we will pay the amount shown on the *Schedule of Benefits*. The Covered Person must have such surgery within 72 hours after the date of the Covered Accident.] ]

**[Paralysis –** Paralysis means the permanent loss of movement of two or more limbs. If a Covered Person is injured in a Covered Accident and the Injury causes paralysis which lasts more than 90 days and is diagnosed by a Physician within 90 days after the Injury, we will pay:

1. The appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee].
2. 50% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Dependent spouse] [Domestic Partner]; and
3. 25% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the Covered Person later dies as a result of the same Covered Accident, we will pay the appropriate Death Benefit or Catastrophic Accident Benefit, less any amounts paid under the Paralysis Benefit.]

**[Burns –** If a Covered Person is burned in a Covered Accident and treated by a Physician or Doctor within 72 hours after the Injury, we will pay the Burn Benefit shown in the *Schedule of Benefits* according to the percentage of body surface burned.

If the Covered Person meets more than one of the burn classifications shown in the *Schedule of Benefits* we will pay the higher amount. We will pay only one of the classification amounts once per Covered Person per Covered Accident.

First degree burns are not covered.]

**[Skin Graft –** If a Covered Person receives a skin graft for a burn for which a benefit was received under the Burn Benefit we will pay the Skin Graft Benefit shown in the *Schedule of Benefits*. We will pay only one of the classification amounts once per Covered Person per Covered Accident.]

### **[Services**

**[Blood/Plasma –** If a Covered Person is injured in a Covered Accident we will pay the amount shown in the *Schedule of Benefits* for blood, plasma or other blood products received within 90 days of the Injury.]

**[Ambulance –** If a Covered Person is injured in a Covered Accident and requires transportation to a Hospital by a professional ambulance service (including "air ambulance" service) within 90 days after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Transportation –** We will pay this benefit if a Covered Person is injured in a Covered Accident and the Injury causes the attending Physician or Doctor to recommend hospital treatment or diagnostic study, which is not available in the city where the Covered Person resides. We will pay the applicable amount shown in the *Schedule of Benefits* for transportation by train, plane, or bus for each Covered Accident. Use of such transportation must begin within 90 days from the date of the Covered Accident. The distance to the location of the hospital treatment or diagnostic study must be greater than 50 miles from the Covered Person's residence.]

**[Family Member Lodging –** We will pay this benefit in amount and for the number of days shown in the *Schedule of Benefits*, for each night's lodging in a Motel/Hotel room for an adult member of the Covered Person's Immediate Family during a Hospital Stay to treat a Covered Person for an Injury due to a Covered Accident.

The Hospital and Motel/Hotel must be more than 100 miles from the Covered Person's residence. The treatment must be prescribed by the Covered Person's local Physician.]

**[Medical Fees –** If a Covered Person is injured in a Covered Accident and receives treatment within 365 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* for:

1. emergency room services and supplies;
2. X-rays;
3. Physician services.

We will pay for these services up to the total amount shown for Medical Fees in the *Schedule of Benefits*, for each Covered Accident.

This benefit is payable if a Covered Person receives initial treatment within 60 days after the Injury.]

**[Prosthesis –** We will pay the amount shown in the *Schedule of Benefits* for each prosthetic device a Covered Person uses as the result of an Injury received in a Covered Accident. Artificial joints, hearing aids, wigs, or dental aids including but not limited to false teeth are not covered.]

**[Appliances –** If a Covered Person is advised by a Physician or Doctor to use a medical appliance as an aid in personal locomotion as the result of an injury received in a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Medical appliance means crutches, wheelchairs, leg braces, back braces and walkers.]

**[Accident Follow-up Treatment –** We will pay the amount shown in the *Schedule of Benefits* when a Covered Person receives follow-up treatment for an Injury received as a result of a Covered Accident. We will pay for a total of six treatments per Covered Accident. You must have received initial treatment within 72 hours of a Covered Accident and follow-up treatment must begin within 30 days of the Covered Accident or discharge from the hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Out-Patient basis.]

**[Physical Therapy –** If a Covered Person is injured in a Covered Accident and that Injury requires physical therapy, we will pay the amount shown in the *Schedule of Benefits* for a maximum of six physical therapy sessions per Covered Accident. A Covered Person must have received initial treatment for the Injury within 72 hours of the Covered Accident and physical therapy must begin within 30 days of the Injury or discharge from the Hospital. All physical therapy sessions for such accident must take place within six months of the Injury or discharge from the Hospital. We will not pay this benefit for the same visit that the Accident Follow-up Treatment benefit is paid.] ]

### **[Health Screening Benefit**

After a Covered Person has been continuously insured for 12 months, we will pay the amount shown in the *Schedule of Benefits* for the Health Screening Tests. This Benefit is payable once [in any 12 month period] [per [Plan] Year].

As used above "Health Screening Test" means:

1. Stress test on a bicycle or treadmill, or using Thallium or similar pharmaceutical agent;
2. Fasting blood glucose test;
3. Blood test for triglycerides;
4. Serum cholesterol test to determine level of HDL and LDL;
5. Bone marrow testing;
6. Breast ultrasound;
7. CA 15-3 (blood test for breast cancer);
8. CA 125 (blood test for ovarian cancer);
9. CEA (blood test for colon cancer);
10. Chest X-ray;
11. Colonoscopy;

12. Flexible sigmoidoscopy;
13. Hemocult stool analysis;
14. Mammography;
15. Pap test;
16. PSA (blood test for prostate cancer);
17. Serum Protein Electrophoresis (blood test for myeloma);
18. Thermography; and
19. Skin review by a dermatologist.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.]

### **[Hospital Benefit**

**Hospital Admission** – We will pay this benefit when a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay within six months of the date of the Injury.

We will pay the Hospital Admission Benefit amount shown in the *Schedule of Benefits*. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

We will pay this benefit once per Hospital Stay.

**Daily In-Hospital Benefit** – If a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay [within 90][365] days] after the Injury, we will pay the amount shown in the *Schedule of Benefits* for each day that you are confined to a Hospital. The length of time shown for Hospital Confinement in the *Schedule of Benefits* is the Maximum Period for which you can collect benefits for Hospital Confinements resulting from the same injury.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.

**[Hospital Intensive Care** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to be confined to a Hospital Intensive Care Unit during a Hospital Stay, we will pay the amount shown in the *Schedule of Benefits* for the number of days shown in the *Schedule of Benefits* per Covered Accident. This benefit is payable in addition to the Daily In-Hospital Benefit above.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.] ]

### **[Dismemberment Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes loss of a hand, foot or sight within 90] 365] days after the Injury we will pay:

1. The amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];

3. 25% of the amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

If a Covered Person loses one hand, one foot or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the *Schedule of Benefits*.

“Dismemberment” means:

1. loss of a hand: the hand is cut off at or above the wrist joint;
2. loss of a foot: the foot is cut off at or above the ankle;
3. loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; or
4. loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If a Covered Person does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment shown in the *Schedule of Benefits*.

If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under this benefit.]

#### **[Accidental Death Benefit**

**Accidental Death** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

[If the Accidental Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.]

**[Accidental Common Carrier Death Benefit** – If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

To receive this benefit the injury must be the result of traveling as a fare-paying passenger on a Common Carrier, as defined below.

“Common Carrier” means:

1. an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
2. a railroad train which is licensed and operated for passenger service only; or
3. a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental Death Benefit.] ]

### **[Catastrophic Accident Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes a Catastrophic Loss within 365 days after the Injury, we will pay:

1. The amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The Catastrophic Accident Benefit is payable once per lifetime for each Covered Person.

“Catastrophic Loss” means an Injury, which results in total and irrecoverable:

1. loss of both hands or both feet;
2. loss of both arms or both legs;
3. loss of use of both arms or both legs;
4. loss of one hand and one foot;
5. loss of one arm and one leg;
6. loss of use of one arm and one leg;
7. Total Blindness;
8. loss of the hearing of both ears; or
9. loss of the ability to speak.

The loss of use of an arm means the loss of function of the entire arm from the shoulder to the fingers.

The loss of use of the leg means the loss of function of the entire leg from the hip to the toes.



The loss of hearing means deafness in both ears, meaning best corrected hearing threshold of 90 dB or greater in the better ear, and such that it cannot be corrected to any functional degree by any procedure, aid or device.

The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

[If a Paralysis or Dismemberment Benefit is paid and the Covered Person is eligible for a Catastrophic Accident Benefit as a result of the same Covered Accident, we will pay the appropriate Catastrophic Accident Benefit, less any amounts paid under the Paralysis or Dismemberment Benefit.]

[If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Accidental Death Benefit, less any amounts paid under this benefit.] ]

## **LIMITATIONS AND EXCLUSIONS**

### **Limitations**

- [1.] Eligibility Waiting Period – No benefits are payable for any Covered Person until the Eligibility Waiting Period shown has been completed. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
- [2.] Reduction Schedule – The Payment Level for the Scheduled Amount payable will be reduced by 50% if a Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

### **Exclusions**

We will not pay benefits for loss contributed to, caused by, or resulting from the following unless specifically provided elsewhere in this Policy:

1. Loss due to sickness, or any benefit for a diagnosis caused or contributed to by a sickness, except as described in *Health Screening Benefits*;
2. Rest care or custodial care and any associated transportation;
3. Dental, eye or hearing care other than those resulting from a Covered Accident;
4. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury [, unless as a result of a medical condition or an act of domestic violence];
5. Loss due to an Injury while participating in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
6. Loss due to an Injury while committing, attempting to commit, or taking part in a felony or assault;
7. Loss due to an Injury while participating in a contest of speed in power driven vehicles or a self propelled conveyance, parachuting, parasailing, bungee jumping, mountain climbing, spelunking, or hang gliding, operating an all terrain vehicle (ATV or dirt bike), SCUBA diving, white water rafting or mountain biking;
8. Loss for Injury while participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received.

9. Loss occurring during air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route
  - b. on a charter flight operated by a scheduled airline; or
  - c. as a passenger for transportation only and not as a pilot or crew member;
10. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
11. Loss due to an Injury resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not provided by or at the direction of a Physician or Doctor;
12. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an Injury occurring or contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
13. Loss due to an Injury arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
14. Loss due to an Injury while driving any taxi, or long-distance or other commercial vehicle in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made.
15. Loss due to an Injury during a period of time that insurance for a Covered Person is not in force;
16. Loss due to an Injury after this Policy has terminated;
17. Loss due to an Injury not provided by or at the direction of a Physician or Doctor, or is inconsistent with standards of medical practice for the applicable condition;
18. Treatment of any Injury outside the United States or Canada;
19. Rendered by any person who is:
  - a. employed or retained by the [Policyholder];
  - b. living in the Covered Person's household;
  - c. a parent, sibling, spouse[,] [domestic partner] or child of a Covered [Employee] or of his spouse; or
  - d. a Covered Person treating himself.

## **CLAIM PROVISIONS**

### **Notice of Claim**

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Covered Accident is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name and the Covered Person's name, address, Policy and Policy Number.

## **Claim Forms**

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

## **Proof of Loss**

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

## **[Notice of Decision**

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

**Review Of Denied Claims** – For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours. ]

### **Time of Payment of Claims**

We will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

### **Payment of Claims**

All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person. Any benefits unpaid at the time of a Covered Person's death will be paid in the following order:

1. to any approved assignee;
2. the Covered Person's beneficiary;
3. a Covered Person's surviving spouse;
4. a Covered Person's estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

### **Change of Beneficiary**

A Covered [Employee] may ask us to change his beneficiary at any time. [The request must be in writing and the change must be approved by us.] If approved, it will go into effect the day the Covered Person signs the request. The change will not have any bearing on payments made before we approved the request.

### **Claimant Cooperation Provision**

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

### **Claim Administration**

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of

fact. All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

### **Payment of Claims to Foreign [Employees]**

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Policy.

### **Physical Examination and Autopsy**

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

### **Legal Actions**

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

### **Recovery of Overpayment**

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

### **[Additional Coverage with the Company]**

We will only pay benefits for a Covered Accident under one Accidental Injury Policy or Certificate if a Covered Person is covered by more than one of our Accidental Injury Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Accidental Injury Policies or Certificates during the period there was more than one Policy or Certificate in force.]

**Unpaid Premium** – When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

## **ADMINISTRATIVE PROVISIONS**

### **Cancellation**

We or the [Policyholder] may cancel this Policy, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination

### **Grace Period**

A Policy Grace Period of [31] [60] [90] days will be granted for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by the Certificate beyond the period for which premium has been accepted; and
2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Policy was in force.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the grace period, insurance will end on the last day of the period for which premiums were paid.

### **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

### **Premium Payment**

The total premium for this Policy is the sum of premiums paid by the [Policyholder] for all Covered Persons below, including any amounts contributed toward the cost of this coverage by Covered Persons. If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

### **Changes in Premium Rates**

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the number of Covered Persons eligible for coverage increases or decreases by more than 10% since the latter of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;

4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Policy; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

### **Premium Audit**

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

## **GENERAL PROVISIONS**

### **Entire Contract; Changes**

This Policy, including the [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

### **Misstatement of Age**

If an age has been misstated on the enrollment form, the Benefits will be those the premium paid would have purchased at the correct age.

### **Certificates**

Where required by law, we will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

### **Assignment**

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

### **Incontestability**

#### **1. Of This Policy**

All statements made by the [Policyholder] to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

## 2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

### **Reporting Requirements**

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

### **Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, we will adjust the premium fairly.

### **Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

### **Compensation Insurance**

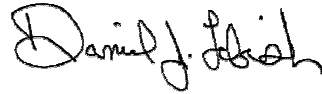
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.



# HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Group Policy.



President

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POLICYHOLDER:	[*]
POLICY NUMBER:	[*]
[PARTICIPATING ORGANIZATION:]	[*]
CERTIFICATE EFFECTIVE DATE:	[*]
STATE OF ISSUE:	[*]

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the [Policyholder] with a revised Certificate or other notice to be given to you.

## PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Certificate.

"You" and "your" refer to the Covered Employee. The "Company", we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

## GROUP ACCIDENTAL INJURY

### Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. Thank you for your loyal patronage.

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## [SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Certificate on the effective dates listed below. A newly-acquired Affiliate may be covered under this Certificate on the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

Affiliate Name	Location	Effective Date
[*]	[*]	[*]

## SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Certificate provisions carefully.

Unless otherwise stated in this Certificate, benefits are payable per Covered Person per Covered Accident. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [The period determined by the [Policyholder's] personnel practices]]

[For [employee]s hired after the Certificate Effective Date: [None] [30] [31] [45] [60] [90] [days] [the [Policyholder]'s next Open Enrollment Period] [The period determined by the [Policyholder's] personnel practices] ]

Benefit	Scheduled Amount		
Accidental Injury	Plan 1	Plan 2	Plan 3
<b>[Fractures]</b>			
Hip/thigh	\$2,000	\$4,000	\$6,000
Vertebrae	\$1,800	\$3,600	\$5,400
Pelvis	\$1,600	\$3,200	\$4,800
Skull (depressed)	\$1,500	\$3,000	\$4,500
Skull (simple)	\$700	\$1,400	\$2,100
Leg	\$1,200	\$2,400	\$3,600
Foot/ankle/knee cap	\$1,000	\$2,000	\$3,000
Forearm/hand	\$1,000	\$2,000	\$3,000
Lower jaw	\$800	\$1,600	\$2,400
Shoulder blade/collar bone	\$800	\$1,600	\$2,400
Upper arm/upper jaw	\$700	\$1,400	\$2,100
Facial bones (except teeth)	\$600	\$1,200	\$1,800
Vertebral processes	\$400	\$800	\$1,200
Coccyx/rib/finger/toe	\$160	\$320	\$480
Wrist/Elbow	\$1000	\$2000	\$3000]
<b>[Dislocations]</b>			
Hip	\$1,350	\$2,700	\$4,050
Knee (not knee cap)	\$950	\$1,900	\$2,850
Shoulder	\$750	\$1,500	\$2,250

Ankle	\$600	\$1,200	\$1,800	
Lower jaw	\$450	\$900	\$1,350	
Wrist	\$375	\$750	\$1,125	
Elbow	\$300	\$600	\$900	
Finger/toe	\$120	\$240	\$360]	
<b>[Lacerations</b>				
Over 6"	\$200	\$400	\$600	
2" to 6"	\$100	\$200	\$300	
Under 2"	\$50	\$100	\$150]	
[Lacerations not requiring stitches	\$25	\$50	\$75]	]
<b>[Concussions</b>	\$50	\$100	\$150]	
<b>[Coma</b>	\$2,500	\$5,000	\$7,500]	
<b>[Emergency Dental Work</b>	\$50	\$100	\$150]	
<b>[Injuries Requiring Surgery</b>				
[Eye injuries				
Requiring surgical repair	\$125	\$250	\$375	
Removal of foreign body	\$25	\$50	\$75]	
[Tendons/ligaments	\$200	\$400	\$600]	
[Ruptured disc	\$100	\$200	\$300]	
[Torn knee cartilage	\$100	\$200	\$300]	
[Internal Injuries	\$500	\$1,000	\$1,500]	
[Exploratory Surgery (without repair)	\$125	\$250	\$375]	]
<b>[Paralysis</b>				
Four limbs (quadriplegia)	\$5000	\$10,000	\$15,000	
Two limbs (paraplegia)	\$2,500	\$5,000	\$7,500]]	
<b>[Burns</b>				
[Second Degree				
Less than 10%	\$100	\$200	\$300	
At least 10% but less than 25%	\$200	\$400	\$600	
At least 25% but less than 35%	\$500	\$1,000	\$1,500	
35% or more	\$1,000	\$2,000	\$3,000 ]	
[Third Degree				
Less than 10%	\$500	\$1,000	\$1,500	
At least 10% but less than 25%	\$3,000	\$6,000	\$9,000	
At least 25% but less than 35%	\$7,000	\$14,000	\$21,000	
35% or more	\$10,000	\$20,000	\$30,000 ]	]

<b>[Skin Graft</b>	25% of the applicable burn benefit]		
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**[Services**

[Blood/plasma	\$100	\$100	\$100]
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[Ambulance	\$50	\$100	\$150]
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[Air ambulance	\$250	\$500	\$750]
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[Transportation			
Train or Plane	\$150	\$300	\$450
Bus	\$75	\$150	\$225
Maximum of 3 trips per [Plan] Year]			

[Family Member Lodging			
Per Night	\$50	\$100	\$150
Maximum	30 days per Covered Accident]		

[Medical fees			
Maximum per accident	\$50	\$100	\$150]

[Prosthesis	\$250	\$500	\$750]
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[Appliances	\$50	\$100	\$150]
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[Accident Follow-up Treatment	\$15	\$30	\$45
Maximum	6 treatments per Covered Accident]		

[Physician Therapy	\$15	\$30	\$45
Maximum	6 treatments per Covered Accident] ]		

**[Health Screening**

Benefit per test	\$50	\$50	\$50]
Maximum	Once per [12 month period] [Plan] Year]		

**[Hospital Admission**

Maximum	\$500	\$1,000	\$1,500
	Once per [Plan] Year]		

**[Daily In-Hospital Benefit**

Benefit per day	\$100	\$200	\$300
Maximum	365 days per Hospital Stay]		

**[Hospital Intensive Care**

Benefit per day	\$100	\$200	\$300
Maximum Benefit	30 days per Hospital Stay]		

**[Accidental Dismemberment**

Loss of hand, foot or sight			
Single loss	\$5,000	\$10,000	\$15,000
Double loss	\$15,000	\$30,000	\$45,000

Loss of one or more fingers or toes	\$500	\$1,000	\$1,500
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Partial Amputation of finger or toe	\$100	\$200	\$300 ]
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<b>[Accidental Death</b>	\$15, 000	\$30,000	\$45, 000]
<b>[Common Carrier Accidental Death</b>	\$50,000	\$100,000	\$200,000]
<b>[Catastrophic Accident</b>	\$50,000	\$100,000	\$200,000]

#### **[Reduction Schedule**

	<b>[Employee]</b>	<b>[Spouse] [Domestic Partner]</b>	<b>[Child]</b>
Rate	50%	50%	50%
Attained Age	70	70	70]

**Minimum Participation Requirement** [5] [Employees] [and] [Dependents]

#### **Rates and Premiums**

**Mode of Premium Payment** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual]

**Premium Due Dates** [Certificate Effective Date and the first day of each  
month thereafter]

[Certificate Effective Date and the first day of each  
calendar quarter thereafter]

Certificate Effective Date and the first day [July] [and]  
[January] thereafter]

**Contributions** The [entire] cost of this insurance is paid by  
[the] [[Policyholder]] [and] [Covered Persons].

**Rates** [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual]  
[Annual] Rate

	<u>24-Hour</u>	<u>Non-Occupational</u>
[Employee]	[*]	[*]
[Employee] and Dependent Child(ren)	[*]	[*]
[[Employee] and [Dependent Spouse] [Domestic Partner] ]	[*]	[*]
[Family]	[*]	[*]
[Composite]	[*]	[*]

#### **DEFINITIONS**

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

**Active Service** means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a[  
scheduled] basis, either at one of the [Employer's] usual places of business or at some other location  
to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][,  
only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an In-Patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

**Affiliate or Affiliated** means a company, location or division while subsidiary to, affiliated with or controlled by the [Policyholder].

**Certificate** means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

**Company** or **we, us, our**, means HM Life Insurance Company, domiciled in Pennsylvania.

**Covered Accident** means an Injury, which:

1. occurs as a result of an accident while the Covered Person is insured under this Certificate, and after any applicable Eligibility Waiting Period; and
2. is not otherwise excluded under the terms of this Certificate

**[Employee]** means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- |   |           |  |
|---|-----------|--|
| [ | [Class 1] | [All [employee]s] of the [Policyholder] who are officers]                |
|   | [Class 2] | [All [employee]s] of the [Policyholder] who are managers or supervisors] |
|   | [Class 3] | [All [employee]s] of the [Policyholder]] at [location] ]                 |
|   | [Class 4] | All other [employee]s] of the [Policyholder]]]                           |

**Covered Person** means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

**Dependent** means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Certificate; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Certificate; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Certificate and who:
  - [a.] is less than [19] [23] [25] [30] years old; or
  - [b.] is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]

[c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered Employee's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19;

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

**[Domestic Partner]** means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a domestic partnership with a different domestic partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]]. ]

**[Domestic Partnership Arrangement]** means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

- 1. joint lease, mortgage or deed;
- 2. joint ownership of a vehicle;
- 3. joint ownership of a checking account or credit account;
- 4. designation of the domestic partner as a beneficiary for the employee's life insurance or retirement benefits;
- 5. designation of the domestic partner as a beneficiary of the employee's will;
- 6. designation of the domestic partner as holding power of attorney for health care; or
- 7. shared household expenses. ]

**Eligibility Waiting Period** means the period of time that must lapse before an [Employee][.] [or] [Dependent] [or] [Domestic Partner] is eligible for this insurance. It will be extended by the number of



days the [Employee] is not in Active Service. We will not pay benefits for an Injury or Injuries sustained during the Eligibility Waiting Period:-

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [and] [Domestic Partner] [Covered Person] must [upon request] [and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]
- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
3. provide any additional reasonable information about his insurability that we request; and
4. undergo a physical examination and testing at our request]. ]

**He, him or his** means an individual, male or female.

**Hospital** means an institution that meets all of the following:

1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
2. it is managed under the supervision of a staff of legally licensed physicians;
3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent or custodial care; or
2. the aged.

**Hospital Intensive Care Unit** means a place which:

1. is a specifically designated area of the hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
2. is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
3. is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
4. is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a twenty four hour basis; and
5. has a doctor assigned to the intensive care unit on a full-time basis.

A Hospital Intensive Care unit is not any of the following step down units:

1. a progressive care unit;
2. a sub-acute intensive care unit;

3. an intermediate care unit;
4. a private monitored room;
5. a surgical recovery room;
6. an observation unit; or
7. any facility not meeting the definition of a hospital intensive care unit as defined in this Certificate.

**Hospital Stay** means a confinement in a Hospital, ordered by a Physician or Doctor for at least 24 consecutive hours when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident or a Covered Sickness. Separate Hospital Stays due to the same Covered Accident or Covered Sickness will be treated as one Hospital Stay unless [(a)] separated by at least [30] [60] [90] days [or (b) a Covered [Employee] returns to Active Service for [15] [30] [45] or more days] between Hospital Stays.

**Immediate Family** - means your spouse, son, daughter, mother, father, sister or brother.

**Injury or Injuries** means bodily injury solely due to a Covered Accident. It includes all complications of and all injuries received from the same accident.

**In-Patient** means confinement [overnight] [,] [for at least] [one full day] [or] [twenty-four (24)] continuous hours for Treatment of a medical condition in a Hospital.

**[Occupational Benefits]** means benefits will be paid if an Injury occurs due to a Covered Accident while a Covered Person is working at any job for pay or benefits.]

**Open Enrollment Period** means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

**Out-Patient** means Treatment received for a medical condition while not confined as an Inpatient in a Hospital.

**Physician or Doctor** means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder]; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse[,], [domestic partner] or child of the Covered Person.

**[Plan] Year or annual or annually** means a period of twelve consecutive months beginning on the Certificate Effective Date and subsequent Anniversary Dates.

**Policyholder** means the entity shown on the cover page of this Certificate.

**[Participating Organization]** means the entity shown on the cover page of this Certificate.]

**Treatment or Medical Treatment** means care, services or supplies, provided by or at the direction of a Physician or Doctor that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury or sickness and are provided during the course of treatment of an injury sustained in a Covered Accident.

## **ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS**

### **Certificate Effective Date**

We agree to provide the Accidental Injury benefits described in this Certificate in consideration of the payment of the premium when due. Insurance coverage begins on the Certificate Effective Date shown on this Certificate's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

### **[Effective Date for Newly-Acquired Affiliates]**

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]s of an Affiliate on its effective date of insurance under this Certificate will be eligible for insurance on that date.]

### **Eligibility**

An [Employee][,][ Dependent] [or][ Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][ Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Policy as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

### **Effective Date**

The Effective Date of this Certificate is shown on the cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

- [1.] submits a complete enrollment form, if any [and we approve that form]; and]
- [2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

- [1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form]][:]  
[and]

[2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and
2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

### **Deferred Effective Date**

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible. Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

### **Late Enrollee**

A person will be considered a late enrollee if he does not apply for insurance under this Certificate within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance under this Certificate within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance under this Certificate within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

### **Effective Date of Changes**

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Certificate or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

### **Termination of Insurance**

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Certificate or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Certificate;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation approved by us; and
- [6.] with respect to an eligible [Dependent] [Domestic Partner], the [day] [first of the month] following the date of the death of the [Employee] or the [day] [first of the month] following the date of divorce from the [Employee], or termination of a Domestic Partnership Arrangement] .

Termination will not affect a claim for a Covered Accident incurred after the Eligibility Waiting Period, if any, and while coverage was in effect.

### **BENEFITS**

The Scheduled Amount payable [for the plan selected] is shown in the *Schedule of Benefits*; unless otherwise noted the amount shown in the Schedule of Benefits is the full amount payable per Covered Person for the benefit, and payable once per Covered Person per Covered Accident. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

### **Accidental Injury Benefits**

**[Fractures** – A fracture is a break in a bone which can be seen by X-ray or other imaging technology that is approved for such use. If a Covered Person fractures a bone in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the Injury, we will pay the amount shown in the *Schedule of Benefits*.

If the fracture requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Multiple Fractures –** If more than one fracture requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured which has the highest benefit amount payable.]

**[Chip Fracture -** A chip fracture is a piece of bone which is completely broken off near a joint. If a Physician diagnoses the fracture as a chip fracture, we will pay 10% of the amount shown in the *Schedule of Benefits* for the affected bone.]

**[Dislocation –** A dislocation is a completely separated joint. If a Covered Person dislocates a joint in a Covered Accident, and it is diagnosed and treated by a Physician or Doctor within [90] [365] days after the accident, we will pay the amount shown in the *Schedule of Benefits*.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the *Schedule of Benefits*.]

**[Recurring Dislocations –** We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If a joint was dislocated before the effective date of a Covered Person insurance under the Certificate and such person dislocates the same joint again, it will not be covered by the Certificate.]

**[Multiple Dislocations –** If more than one dislocation requiring either open or closed reduction occurs in any one Covered Accident, we will pay the amounts shown in the *Schedule of Benefits* for each dislocation. However, we will pay no more than 200% of the benefit amount for the joint dislocated which has the highest benefit amount payable.]

**[Partial Dislocation –** A partial dislocation is one in which the joint is not completely separated. If a Physician or Doctor diagnoses and treats the Injury as a partial dislocation, we will pay 25% of the amount shown in the *Schedule of Benefits* for the affected joint.]

**[Fracture and Dislocation –** If a Covered Person fractures a bone, and dislocates a joint in the same Injury, we will pay for both; however, we will pay no more than 200% of the benefit amount for the bone fractured or joint dislocated, which has the highest benefit amount payable.]

**[Lacerations –** If a Covered Person receives a laceration in a Covered Accident and the laceration is repaired with stitches by a Physician or Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the *Schedule of Benefits*. The benefit amount paid will be based on the length of the laceration.

[If a Covered Person receives a laceration in a Covered Accident and the laceration does not require stitches but is treated by a Physician or Doctor within 72 after the accident, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

If a Covered Person suffers multiple lacerations in a Covered Accident and the lacerations are repaired with [or without] stitches by a Physician or Doctor within 72 hours after the Injury, we will pay this benefit based on the largest single laceration as shown in the *Schedule of Benefits*.

As used above “stitches” means stitches, sutures or medical adhesive.]

**[Concussion –** If a Covered Person sustains a concussion as the result of Injuries received in a Covered Accident we will pay the amount shown in the *Schedule of Benefits*. The Covered Person must be diagnosed by a Physician or Doctor within 72 hours after the date of the Covered Accident using any type of medical imaging procedures (CAT scans, MRI, and/or X-ray are examples of medical imaging procedures).]

**[Coma –** If a Covered Person suffers a coma lasting [15] [30] days or more as the result of a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Coma means a profound state of unconsciousness caused by a Covered Accident that lasts for a period of 24 to 48 consecutive

hours from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician or Doctor. The Diagnosis of Coma must indicate that permanent neurological deficit is present.]

**[Emergency Dental Work –** We will pay the amount shown in the *Schedule of Benefits* if a Covered Person receives an Injury to sound natural teeth as the result of a Covered Accident.]

### **[Injuries Requiring Surgery**

**[Eye Injuries –** If a Covered Person injures an eye (or eyes) in a Covered Accident and surgical repair is performed by a Physician or Doctor within 90 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* per eye. If a Physician or Doctor removes a foreign body from a Covered Person's eye, with or without anesthesia, we will pay the amount shown in the *Schedule of Benefits*.]

**[Tendons and Ligaments –** If a Covered Person tears, severs or ruptures a tendon or ligament in a Covered Accident, receives treatment from a Physician or Doctor within 60 days, and has surgical repair within 90 days after the Injury we will pay the appropriate amount shown in the *Schedule of Benefits*. The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

If multiple of tendons or ligaments repaired we will pay no more than 200% of the benefit amount shown in the *Schedule of Benefits*.

If a Covered Person is in a Covered Accident and fractures a bone or dislocates a joint, and tears, severs or ruptures a tendon or ligament, we will pay only one benefit. We will pay the largest of the fracture benefit, the Dislocation Benefit, or the Tendon and Ligament Benefit shown in the *Schedule of Benefits*.]

**[Ruptured Disc –** If a Covered Person ruptures a disc in their spine in a Covered Accident, receives treatment from a Physician or Doctor within 60 days after the accident and has surgical repair by a Physician or Doctor within one year after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Torn Knee Cartilage –** We will pay this benefit in the amount shown in the *Schedule of Benefits* if a Covered Person is injured in a Covered Accident and:

1. the Injury resulted in torn knee cartilage;
2. such Injury requires treatment by a Physician or Doctor within 60 days from the date of the Covered Accident; and
3. such Injury requires repair by surgical operation within 365 days from the date of the Covered Accident.]

**[Internal Injuries –** We will pay this benefit as shown in the *Schedule of Benefits* if a Covered Person has internal injuries as the result of a Covered Accident which results in open abdominal or thoracic surgery.]

**[Exploratory Surgery –** If as the result of an Injury in a Covered Accident a Covered Person has exploratory surgery (without repair), we will pay the amount shown on the *Schedule of Benefits*. The Covered Person must have such surgery within 72 hours after the date of the Covered Accident.] ]

**[Paralysis –** Paralysis means the permanent loss of movement of two or more limbs. If a Covered Person is injured in a Covered Accident and the Injury causes paralysis which lasts more than 90 days and is diagnosed by a Physician within 90 days after the Injury, we will pay:

1. The appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee].

2. 50% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is the [Dependent spouse] [Domestic Partner]; and
3. 25% of the appropriate amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the Covered Person later dies as a result of the same Covered Accident, we will pay the appropriate Death Benefit or Catastrophic Accident Benefit, less any amounts paid under the Paralysis Benefit.]

**[Burns –** If a Covered Person is burned in a Covered Accident and treated by a Physician or Doctor within 72 hours after the Injury, we will pay the Burn Benefit shown in the *Schedule of Benefits* according to the percentage of body surface burned.

If the Covered Person meets more than one of the burn classifications shown in the *Schedule of Benefits* we will pay the higher amount. We will pay only one of the classification amounts once per Covered Person per Covered Accident.

First degree burns are not covered.]

**[Skin Graft –** If a Covered Person receives a skin graft for a burn for which a benefit was received under the Burn Benefit we will pay the Skin Graft Benefit shown in the *Schedule of Benefits*. We will pay only one of the classification amounts once per Covered Person per Covered Accident.]

#### **[Services**

**[Blood/Plasma –** If a Covered Person is injured in a Covered Accident we will pay the amount shown in the *Schedule of Benefits* for blood, plasma or other blood products received within 90 days of the Injury.]

**[Ambulance –** If a Covered Person is injured in a Covered Accident and requires transportation to a Hospital by a professional ambulance service (including "air ambulance" service) within 90 days after the Injury, we will pay the appropriate amount shown in the *Schedule of Benefits*.]

**[Transportation –** We will pay this benefit if a Covered Person is injured in a Covered Accident and the Injury causes the attending Physician or Doctor to recommend hospital treatment or diagnostic study, which is not available in the city where the Covered Person resides. We will pay the applicable amount shown in the *Schedule of Benefits* for transportation by train, plane, or bus for each Covered Accident. Use of such transportation must begin within 90 days from the date of the Covered Accident. The distance to the location of the hospital treatment or diagnostic study must be greater than 50 miles from the Covered Person's residence.]

**[Family Member Lodging –** We will pay this benefit in amount and for the number of days shown in the *Schedule of Benefits*, for each night's lodging in a Motel/Hotel room for an adult member of the Covered Person's Immediate Family during a Hospital Stay to treat a Covered Person for an Injury due to a Covered Accident.

The Hospital and Motel/Hotel must be more than 100 miles from the Covered Person's residence. The treatment must be prescribed by the Covered Person's local Physician.]

**[Medical Fees –** If a Covered Person is injured in a Covered Accident and receives treatment within 365 days after the Injury, we will pay the amount shown in the *Schedule of Benefits* for:

1. emergency room services and supplies;



2. X-rays;
3. Physician services.

We will pay for these services up to the total amount shown for Medical Fees in the *Schedule of Benefits*, for each Covered Accident.

This benefit is payable if a Covered Person receives initial treatment within 60 days after the Injury.]

**[Prosthesis –** We will pay the amount shown in the *Schedule of Benefits* for each prosthetic device a Covered Person uses as the result of an Injury received in a Covered Accident. Artificial joints, hearing aids, wigs, or dental aids including but not limited to false teeth are not covered.]

**[Appliances –** If a Covered Person is advised by a Physician or Doctor to use a medical appliance as an aid in personal locomotion as the result of an injury received in a Covered Accident, we will pay the amount shown in the *Schedule of Benefits*. Medical appliance means crutches, wheelchairs, leg braces, back braces and walkers.]

**[Accident Follow-up Treatment –** We will pay the amount shown in the *Schedule of Benefits* when a Covered Person receives follow-up treatment for an Injury received as a result of a Covered Accident. We will pay for a total of six treatments per Covered Accident. You must have received initial treatment within 72 hours of a Covered Accident and follow-up treatment must begin within 30 days of the Covered Accident or discharge from the hospital. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Out-Patient basis.]

**[Physical Therapy –** If a Covered Person is injured in a Covered Accident and that Injury requires physical therapy, we will pay the amount shown in the *Schedule of Benefits* for a maximum of six physical therapy sessions per Covered Accident. A Covered Person must have received initial treatment for the Injury within 72 hours of the Covered Accident and physical therapy must begin within 30 days of the Injury or discharge from the Hospital. All physical therapy sessions for such accident must take place within six months of the Injury or discharge from the Hospital. We will not pay this benefit for the same visit that the Accident Follow-up Treatment benefit is paid.]       ]

### **[Health Screening Benefit**

After a Covered Person has been continuously insured for 12 months, we will pay the amount shown in the *Schedule of Benefits* for the Health Screening Tests. This Benefit is payable once [in any 12 month period] [per [Plan] Year].

As used above "Health Screening Test" means:

1. Stress test on a bicycle or treadmill, or using Thallium or similar pharmaceutical agent;
2. Fasting blood glucose test;
3. Blood test for triglycerides;
4. Serum cholesterol test to determine level of HDL and LDL;
5. Bone marrow testing;
6. Breast ultrasound;
7. CA 15-3 (blood test for breast cancer);
8. CA 125 (blood test for ovarian cancer);
9. CEA (blood test for colon cancer);

10. Chest X-ray;
11. Colonoscopy;
12. Flexible sigmoidoscopy;
13. Hemocult stool analysis;
14. Mammography;
15. Pap test;
16. PSA (blood test for prostate cancer);
17. Serum Protein Electrophoresis (blood test for myeloma);
18. Thermography; and
19. Skin review by a dermatologist.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.]

#### **[Hospital Benefit**

**Hospital Admission –** We will pay this benefit when a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay within six months of the date of the Injury.

We will pay the Hospital Admission Benefit amount shown in the *Schedule of Benefits*. We will not pay this benefit for confinement to an observation unit, or for emergency room treatment or outpatient treatment.

We will pay this benefit once per Hospital Stay.

**Daily In-Hospital Benefit –** If a Covered Person is injured in a Covered Accident and the Injury requires a Hospital Stay [within [90][365] days] after the Injury, we will pay the amount shown in the *Schedule of Benefits* for each day that you are confined to a Hospital. The length of time shown for Hospital Confinement in the *Schedule of Benefits* is the Maximum Period for which you can collect benefits for Hospital Confinements resulting from the same injury.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.

**[Hospital Intensive Care –** If a Covered Person is injured in a Covered Accident and the Injury causes such person to be confined to a Hospital Intensive Care Unit during a Hospital Stay, we will pay the amount shown in the *Schedule of Benefits* for the number of days shown in the *Schedule of Benefits* per Covered Accident. This benefit is payable in addition to the Daily In-Hospital Benefit above.

This benefit is payable once per Hospital Stay even if the confinement is caused by more than one Injury.] ]

#### **[Dismemberment Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes loss of a hand, foot or sight within [90] [365] days after the Injury we will pay:

1. The amount shown in the *Schedule of Benefits* if the Covered Person is the [Employee];

2. 50% of the amount shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

If a Covered Person loses one hand, one foot or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the *Schedule of Benefits*.

If a Covered Person loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the *Schedule of Benefits*.

“Dismemberment” means:

1. loss of a hand: the hand is cut off at or above the wrist joint;
2. loss of a foot: the foot is cut off at or above the ankle;
3. loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable; or
4. loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If a Covered Person does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment shown in the *Schedule of Benefits*.

If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under this benefit.]

### **[Accidental Death Benefit**

**Accidental Death –** If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Accidental Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

[If the Accidental Death Benefit is paid, we will not pay the Accidental Common Carrier Death Benefit.]

**[Accidental Common Carrier Death Benefit –** If a Covered Person is injured in a Covered Accident and the Injury causes such person to die within [90] [365] days after the accident, we will pay:

1. The amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];

3. 25% of the amount of the Accidental Common Carrier Death Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

To receive this benefit the injury must be the result of traveling as a fare-paying passenger on a Common Carrier, as defined below.

“Common Carrier” means:

1. an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
2. a railroad train which is licensed and operated for passenger service only; or
3. a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

If the Accidental Common Carrier Death Benefit is paid, we will not pay the Accidental Death Benefit.] ]

### **[Catastrophic Accident Benefit**

If a Covered Person is injured in a Covered Accident and the Injury causes a Catastrophic Loss within 365 days after the Injury, we will pay:

1. The amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is the [Employee];
2. 50% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* the Covered Person is the [Dependent spouse] [Domestic Partner];
3. 25% of the amount of the Catastrophic Accident Benefit shown in the *Schedule of Benefits* if the Covered Person is a [Dependent child].

The Catastrophic Accident Benefit is payable once per lifetime for each Covered Person.

“Catastrophic Loss” means an Injury, which results in total and irrecoverable:

1. loss of both hands or both feet;
2. loss of both arms or both legs;
3. loss of use of both arms or both legs;
4. loss of one hand and one foot;
5. loss of one arm and one leg;
6. loss of use of one arm and one leg;
7. Total Blindness;
8. loss of the hearing of both ears; or
9. loss of the ability to speak.

The loss of use of an arm means the loss of function of the entire arm from the shoulder to the fingers.

The loss of use of the leg means the loss of function of the entire leg from the hip to the toes.

The loss of hearing means deafness in both ears, meaning best corrected hearing threshold of 90 dB or greater in the better ear, and such that it cannot be corrected to any functional degree by any procedure, aid or device.

The loss of the ability to speak means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

[If a Paralysis or Dismemberment Benefit is paid and the Covered Person is eligible for a Catastrophic Accident Benefit as a result of the same Covered Accident, we will pay the appropriate Catastrophic Accident Benefit, less any amounts paid under the Paralysis or Dismemberment Benefit.]

[If this benefit is paid and the Covered Person [later dies] [dies with 365 days] as a result of the same Covered Accident, we will pay the appropriate Accidental Death Benefit, less any amounts paid under this benefit.] ]

## **LIMITATIONS AND EXCLUSIONS**

### **Limitations**

- [1.] Eligibility Waiting Period - No benefits are payable for any Covered Person until the Eligibility Waiting Period shown has been completed. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
- [2.] Reduction Schedule - The Payment Level for the Scheduled Amount payable will be reduced by 50% if a Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

### **Exclusions**

We will not pay benefits for loss contributed to, caused by, or resulting from the following unless specifically provided elsewhere in this Policy:

1. Loss due to sickness, or any benefit for a diagnosis caused or contributed to by a sickness, except as described in *Health Screening Benefits*;
2. Rest care or custodial care and any associated transportation;
3. Dental, eye or hearing care other than those resulting from a Covered Accident;
4. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury [, unless as a result of a medical condition or an act of domestic violence];
5. Loss due to an Injury while participating in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
6. Loss due to an Injury while committing, attempting to commit, or taking part in a felony or assault;
7. Loss due to an Injury while participating in a contest of speed in power driven vehicles or a self propelled conveyance, parachuting, parasailing, bungee jumping, mountain climbing, spelunking, or hang gliding, operating an all terrain vehicle (ATV or dirt bike), SCUBA diving, white water rafting or mountain biking;

8. Loss for Injury while participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received.
9. Loss occurring during air travel, except:
  - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route
  - b. on a charter flight operated by a scheduled airline; or
  - c. as a passenger for transportation only and not as a pilot or crew member;
10. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
11. Loss due to an Injury resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not provided by or at the direction of a Physician or Doctor;
12. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an Injury occurring or contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
13. Loss due to an Injury arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
14. Loss due to an Injury while driving any taxi, or long-distance or other commercial vehicle in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made.
15. Loss due to an Injury during a period of time that insurance for a Covered Person is not in force;
16. Loss due to an Injury after this Policy has terminated;
17. Loss due to an Injury not provided by or at the direction of a Physician or Doctor, or is inconsistent with standards of medical practice for the applicable condition;
18. Treatment of any Injury outside the United States or Canada;
19. Rendered by any person who is:
  - a. employed or retained by the [Policyholder];
  - b. living in the Covered Person's household;
  - c. a parent, sibling, spouse[,], [domestic partner] or child of a Covered [Employee] or of his spouse; or
  - d. a Covered Person treating himself.

## **CLAIM PROVISIONS**

### **Notice of Claim**

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Covered Accident is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name and the Covered Person's name, address, and [Policy] [Certificate] Number.

## **Claim Forms**

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Certificate for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

## **Proof of Loss**

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

## **[Notice of Decision**

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

**Review Of Denied Claims** – For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific Certificate provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours. ]

### **Time of Payment of Claims**

We will pay benefits due under this Certificate for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

### **Payment of Claims**

All benefits will be paid in United States currency. All benefits payable under this Certificate, unless otherwise stated, will be payable to the Covered Person. Any benefits unpaid at the time of a Covered Person's death will be paid in the following order:

1. to any approved assignee;
2. the Covered Person's beneficiary;
3. a Covered Person's surviving spouse;
4. a Covered Person's estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

### **Change of Beneficiary**

A Covered [Employee] may ask us to change his beneficiary at any time. [The request must be in writing and the change must be approved by us.] If approved, it will go into effect the day the Covered Person signs the request. The change will not have any bearing on payments made before we approved the request.

### **Claimant Cooperation Provision**

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.



## **Claim Administration**

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Certificate and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact. All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Certificate.

We may contract with another entity to perform this function on our behalf.

## **Payment of Claims to Foreign [Employees]**

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Certificate.

## **Physical Examination and Autopsy**

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

## **Legal Actions**

No action at law or in equity may be brought to recover under this Certificate less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Certificate. No such action will be brought more than three years after the time such written proof of loss must be furnished.

## **Recovery of Overpayment**

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Certificate.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

### **[Additional Coverage with the Company]**

We will only pay benefits for a Covered Accident under one Accidental Injury Policy or Certificate if a Covered Person is covered by more than one of our Accidental Injury Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Accidental Injury Policies or Certificates during the period there was more than one Policy or Certificate in force.]

**Unpaid Premium** – When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

### **ADMINISTRATIVE PROVISIONS**

#### **Cancellation**

We or the [Policyholder] may cancel the coverage provided by this Certificate, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid by the [Policyholder] when due, we will cancel this Certificate at the end of the last period for which premium was paid, subject to the Grace Period provision. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination.

#### **Grace Period**

The [Policyholder] will be granted a Grace Period of [30] [31] [60] [90] days for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by this Certificate beyond the period for which premium has been accepted; and
2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Certificate will be in force during the Grace Period. If the required premiums are not paid by the [Policyholder] during the Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Certificate was in force.

If a Covered Person's insurance under this Certificate is being continued under Continuation of Coverage, such person will be granted an individual Grace Period of 31 days for payment of required premiums due.

If the required premiums are not paid by the Covered Person during the individual Grace Period, such person's insurance will end on the last day of the individual Grace Period. A Covered Person's insurance under this Certificate will remain in force during the individual Grace Period.

The Covered Person is liable to us for any unpaid premium for the time their coverage under this Certificate is being continued under Continuation of Coverage. .

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

## **Premiums**

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Certificate will be based on the rates, agreed to by the [Policyholder] or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected by the [Policyholder]. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

## **Premium Payment**

The total premium for the insurance provided by this Certificate is the sum of premiums paid:

1. by the [Policyholder] for all Covered Persons other than those described in (2) below, including any amounts contributed toward the cost of this coverage by Covered Persons; and
1. by Covered Persons who remain eligible for coverage under the *Continuation of Coverage* provision of this Certificate.

If any premium is not paid when due, this Certificate will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

## **Changes in Premium Rates**

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the initial effective date of the coverage provided by this Certificate. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Certificate change;
2. the number of [Employee]s eligible for coverage increases or decreases by more than 10% since the latter of the initial effective date and the date of the last renewal of the coverage provided by this Certificate;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Certificate; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

## **Premium Audit**

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

## **GENERAL PROVISIONS**

### **Entire Contract; Changes**

The Policy [and this Certificate], including [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in the Policy [or this Certificate] will be valid until approved by one of our executive officers and endorsed on or attached to the Policy or this Certificate. No agent has authority to change the Policy [or this Certificate], or to waive any of the Policy's [or Certificate's] provisions.

### **Misstatement of Age**

If an age has been misstated on the enrollment form the Benefits will be those the premium paid would have purchased at the correct age.

### **Certificates**

Where required by law, we will provide a Certificate of Insurance for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

### **Assignment**

The rights and benefits under this Certificate may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

### **Incontestability**

#### **1. [Policyholder]**

All statements made by the [Policyholder] to obtain the coverage provided by this Certificate are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of the coverage provided by this Certificate unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the initial effective date of the coverage provided by this Certificate, no such statement will cause the coverage provided by this Certificate to be contested except for fraud.

#### **2. Covered Person**

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

**Reporting Requirements**

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Certificate Effective Date;
2. the number of persons who are insured after the Certificate Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

**Clerical Error**

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Certificate. If such error or delay is found, we will adjust the premium fairly.

**Conformity with Statutes**

Any provisions in conflict with the requirements of any state or federal law that applies to this Certificate are automatically changed to satisfy the minimum requirements of such laws.

**Compensation Insurance**

This Certificate is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

<i>SERFF Tracking Number:</i>	<i>HMRK-125683769</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>HM Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39219</i>
<i>Company Tracking Number:</i>	<i>HMP-ACC 308</i>		
<i>TOI:</i>	<i>H02G Group Health - Accident Only</i>	<i>Sub-TOI:</i>	<i>H02G.000 Health - Accident Only</i>
<i>Product Name:</i>	<i>Accident Insurance</i>		
<i>Project Name/Number:</i>	<i>Accident/HMP-ACC 308</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number:	HMRK-125683769	State:	Arkansas
Filing Company:	HM Life Insurance Company	State Tracking Number:	39219
Company Tracking Number:	HMP-ACC 308		
TOI:	H02G Group Health - Accident Only	Sub-TOI:	H02G.000 Health - Accident Only
Product Name:	Accident Insurance		
Project Name/Number:	Accident/HMP-ACC 308		

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	06/11/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Readability Certification.pdf			

<b>Satisfied -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	06/11/2008
<b>Comments:</b>				
	Previously approved by Department -May 23, 2008 (SERFF Tracking Number HMRK-125652016).			
<b>Attachment:</b>				
	HMWA 308 - Worksite application - generic.pdf			

<b>Satisfied -Name:</b>	Summary of Variables	<b>Review Status:</b>	Approved-Closed	06/11/2008
<b>Comments:</b>				
<b>Attachment:</b>				
	Summary of Variables HM-ACC 308.pdf			

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

This is to certify that the following forms comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch Reading Ease Score of:

<u>FORM NO.</u>	<u>DESCRIPTION</u>	<u>FLESH SCORE</u>
HMP-ACC 308	Accident	56
HMC-ACC 308	Accident	51.3

  
\_\_\_\_\_  
Signed by Company Officer

May 27, 2008  
Date

Domenic Palmieri  
Name

Senior Vice President – Finance  
Title





Administrative Offices  
P.O. Box 535061  
Pittsburgh, PA 15253-5061  
1-800-833-1115

PO BOX 535061, SUITE P6518  
PITTSBURGH, PA 15253-5061

### Application for Group Insurance

Please Type or Print – Must be completed in full  
Indicate "N/A" or "none" if item does not apply.

## 1. Applicant

Full Legal Name of Group (to appear on Policy)	Tax ID Number	( ) Business Telephone
Address	Zip + 4	( ) Fax Number
Delivery Address (If Different from Above)		E-Mail
Nature of Business	SIC Code	Internet
* If "Other" describe:		<input type="checkbox"/> Corp. <input type="checkbox"/> Gov
		<input type="checkbox"/> Partner <input type="checkbox"/> Other *

☐ **Affiliates to be Insured:** ☐ No ☐ Yes (List below; if additional space is needed, please attached a separate sheet)

<u>Full Legal Name and Address of Affiliates</u>	<u>City/State</u>	<u>Nature of Business</u>
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## 2. Coverage Requested

Coverage	Check all that apply		
<input type="checkbox"/> Specified Critical Illness	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Hospital Indemnity	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Accident	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Disability	<input type="checkbox"/> Employee		
<input type="checkbox"/> Term Life/AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Whole Life	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child

This application must be accompanied by the Coverage Transmittal form and the proposal for the coverage requested.

<b>3. Requested Effective Date:</b> ____/____/____	<b>4. # Eligible Employees</b> ____
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**5. Will the requested insurance replace existing insurance?** ☐ Yes ☐ No

If "Yes" please check all that apply: ☐ Critical Illness ☐ Hospital Indemnity ☐ Accident  
☐ Disability ☐ Term Life / AD&D ☐ Whole Life

**6. Is this a Section 125 plan?** ☐ Yes ☐ No

### APPLICANT AGREES THAT

The insurance coverage requested and requested effective date must be approved by **HM Life Insurance Company** under its current rules and practices including Active Work, Evidence of Insurability and Pre-existing Condition provisions. All options and special requests are subject to Home Office approval.

No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage. All materials describing this coverage must be approved in writing by **HM Life** prior to distribution. Note: Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until notified.

Premium rates quoted were based on the data submitted to **HM Life**. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life's** approval of the coverage requested.

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Print Name of Applicant's Authorized Representative

---

Signature of Applicant's Authorized Representative

---

Date

---

Title

---

Signature of Witness and/or Agent

---

Location, City/State

---

Name of Witness and/or Agent

---

Agent License Number

#### **FRAUD NOTICE** *(Please read carefully)*

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In Arkansas, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For your protection, California requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

In the District of Columbia, **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

In Kentucky, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Any application for insurance in writing by the applicant shall be altered solely by the applicant or by his written consent; except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

In Maryland any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Ohio, any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Oklahoma, **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**VARIABLES, CUSTOMIZED PROVISIONS, AND FORMAT**  
**HM Life Insurance Company**  
**HMP-ACC 308, et al**

HM Life's policy forms are constructed in a way that allows us to select appropriate variables for each client either upon request or as required by applicable.

Policy forms will only be issued to eligible groups as defined by applicable law. Certificates of Insurance are issued to all group policyholders and/or participating employers for distribution to eligible members.

The enclosed policy form filing includes standard and variable provisions – there are several kinds of variables which are bracketed:

- Optional benefit provisions provided upon request and contract provisions, which are used in specific situations depending upon the requested plan design.
- Variable amounts, periods, and/or durations, all of which are shown in brackets. Such amount, period or duration used will depend on the product design requested by the client, subject to underwriting approval.
- Optional wording within a sentence or paragraph – where alternate wording is available, each variation is bracketed and shown in the enclosed policy forms.

An asterisk within bracket may be used to designate a form number, form type and/or applicable class in the footer; a name, number or date on the cover page; an affiliate name, location or effective date; or the dollar value of the premium due.

Common terms within the form may be substituted with similar terms, for example:

[Policyholder] – Employer, Participating Organization Association, Union, Indian Nation, etc. or similar term may be substituted for Policyholder provided benefits are provided on a group basis in a manner that precludes individual selection.

[Employee] – Associate, Member, Participant, etc. or similar term may be substituted for Employee

[Plan] – Calendar or Benefit may be substituted.

References to time periods, such as 180 days, may be converted to their monthly equivalent where practical upon request.

All exclusions and limitations may be included or deleted in their entirety. Optional wording within the exclusion or limitation is shown in brackets. Definitions that do not apply to the benefit description may be deleted in their entirety.

The policyholder generally determines eligibility and service waiting periods, if any, for their employees. Thus the definition of any insured person, and/or any service waiting period associated with such person's eligibility for benefits is subject to change. We will not agree to a definition of employee or a service waiting period that is not applied consistently to all employees within a given class.

Additional variations not shown in the enclosed policy form may be agreed upon as a result of negotiations between HM Life and the Policyholder. However, we will not agree to any provision, which is, to the best of our knowledge and belief, ambiguous or unclear, or inconsistent with any law or regulation of the state or federal government.

The attached forms are submitted in final printed form in 10-point type on 8 1/2 by 11 pages. The certificate may be printed in a booklet format (5 1/2 by 8 1/2 pages), if requested by the Policyholder. We may issue certificates in a foreign language, based on a direct translation of the filed wording.